**ARIZONA DEPARTMENT OF ECONOMIC SECURITY**

**Division of Children, Youth, and Families**

# Child Welfare Privatization

## APPENDIX 1:

## CASE EXAMPLES & INTERVIEWS WITH PRIVATE EXECUTIVES

A report prepared by McCullough & Associates, Inc.

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## CASE EXAMPLES & INTERVIEWS WITH PRIVATE AGENCY EXECUTIVES

### Overview

Arizona must weigh options for privatizing some or all portions of case management services in five overlapping areas: (1) Hotline functions, (2) Investigations, (3) In-home Services, (4) Out-of-Home Services, (5) Adoption/Adoption Subsidy.

*Areas Covered in the Case Studies*

The authors are aware of no State in which Hotline functions have been privatized so no case study is offered for that area. Similarly, the initial protective service investigation function also remains clearly in the hands of public child welfare workers or, in a few states, resides with the Sheriff's departments. As a result, no case studies are provided. However, as many States reassess their approach to investigations and create differential response systems, some are turning to private agencies to provide services to low-risk children and families who do not require an open child protective service case but do need access to community services, similar to Arizona's former Family Builders. Should Arizona decide that is an area worthy of further study, case examples will be provided for the Iowa Community Diversion program (launched in 2005).

What this section clearly demonstrates is that no two case management initiatives are alike. It includes:

- A newly awarded Family Network Lead Agency contract in Massachusetts in which case management responsibilities are shared between the public and private agency, with no-financial risk or incentives to the provider.
- A performance-based contract for children in the foster care system in Missouri in which the contractor has total responsibility for case management (but no responsibility for room and board costs in the first year).
- A foster care case rate pilot project in Cuyahoga County (Cleveland), Ohio. This is typical of the most common form of privatization in child welfare.
- A comprehensive case management Lead Agency contract in Florida's Community-Based Care System where the Lead agency is responsible for all services from referral at the time of investigation to permanency, including accessing health and behavioral health care for the enrolled children.
- A recently awarded reunification and family preservation contract in Kansas.
- Two approaches to adoption contracting—a Massachusetts model and the Kansas case rate adoption contract (Note: The design of the Kansas adoption contract in the most recent 2005 procurement differs from the model presented.)

## Massachusetts- A No-Risk, Dual Case Management Model

### Background

Massachusetts has a long history of contracting for an array of child welfare services, including in-home and out-of-home care services and adoption. At one point in the 1980s, the State also contracted for Protective Investigations for some cases through one private nonprofit agency (MSPCC). The MSPCC contract granted full case management responsibility to the provider. Several years after it was launched, the MSPCC contract was terminated after sustained pressure from critics, notably the Labor Union. The only private agencies that have had full case management responsibility since that time are those that serve a limited number of the Department's adoption cases. In all other instances, case management services are either solely the responsibility of the Department staff or a shared responsibility—with private contractors providing care management in collaboration with Department social workers.

The State was one of the early pioneers in implementing a risk-based contract with lead agencies to provide services to youth in need of therapeutic levels of out-of-home care. The *Commonworks* program was in place from 1996 to September 2005. At present, the Department is in the process of dismantling *Commonworks* and a similar lead agency contract for Family-based services and integrating both of those services and others under a new Family Network Initiative.

The following pages provide an overview of the still evolving new initiative in which private Area Lead Agencies will share responsibilities for case management services for children referred by the Department.

### Family Network Area Lead Agencies

Through its *Family Network Initiative*, DSS is engaging providers in the work of creating an integrated, values-based service system for children and families. The Department has noted that the scope and scale of *Family Networks* –a statewide initiative, integrating $300M in placement and family-based purchased services, is the largest undertaking for the department in over a decade. The Request for Responses (RFR) for Area Lead Agencies was issued in February 2005.

On July 1, 2005, DSS began its partnership with provider agencies serving as *Family Networks* Area Lead Agencies. There are 29 Lead Agencies in 6 regions with a total of about $12 M contracts. This represents an $8 M increase over the administrative costs of the previous *Commonworks* and Family-based contracts. The State has released a purchased services RFI that describes the proposed critical services that will be provided through the Family Networks.

The first phase of implementation will focus on decreasing the use of residential services by supporting families whose children are at risk of or already in long-term residential placement in caring for their children at home.

DSS expects that over time, resources previously spent on managing and purchasing long-term residential placement will be redeployed and used to support an increasing capacity of family and community based services. This effort, in turn, will support more families in caring for their children without the need for long-term residential placement.

The total anticipated duration of these contracts is July 1, 2005 through June 30, 2014. Duration of all contracts awarded is dependent upon appropriation funding and performance.

*A Dual Case Management Model*

DSS retains the following areas of decision-making authority.

- **DSS Service Plans:** DSS social workers are responsible for establishing and making changes to the service plan goal, outcomes, and tasks. Lead Agencies are key contributors to recognizing in a timely way that a service plan needs to be revised to address new issues or lack of progress. DSS social workers will participate in the family team meetings convened by the Lead Agency.
- **Placement Services:** DSS retains decisions for placement related services for most children. When DSS determines that a child is best cared for through placement outside their home, DSS will select the service provider, the level of care, and the location for initial and any subsequent placements. DSS will make determinations regarding the type, level, and scope of advocacy on behalf of the child's educational and medical needs. The exception to this role is the group of children and families with whom the Area Lead Agency works to avoid or shorten residential placement through care management (see below).
- **Permanency Plans:** DSS retains responsibility for establishing permanency plans and approving a permanent caretaker resource. To support effective permanency planning, the Lead Agency will work with parents and DSS to gather information on factors leading to permanency, including recommendations on kinship placement. DSS is responsible for decisions regarding case closure.
- **Legal Decisions and Proceedings:** DSS staff attorneys remain responsible for representing the Department in all legal proceedings and Court appearances. DSS attorneys work with DSS and Lead Agency staff to develop court petitions and recommendations to the Court regarding changes in children's custody and termination of parental rights. DSS remains responsible for all legal decisions, including the following:
  - Change in custody or care of child
  - Return custody of child to his/ her family
  - Recommending to the Court termination of parental rights

The Lead Agency Responsibilities

- **Convening Family Teams:** The Lead Agency is responsible for convening family team meetings. The DSS social worker who established the original service plan with the family will be an important member of these family teams.
- **Service Coordination:** For children and families in need of family-based services, the role of the Lead Agency is to identify and coordinate the services necessary to achieve the goal and outcomes identified in the DSS service plan. The Lead Agency staff will do this by bridging the DSS service plan with the treatment plans established by each provider working with the family.

- Access and Referral: DSS will establish criteria and a process for identifying which families to refer to the Lead Agency for coordination services. The referral could come at any point in the family's involvement with DSS – at initial engagement, after DSS completes an assessment, after the service plan is established, or after months of involvement in response to changing circumstances. The Lead Agency will have no right to refuse a referral because of the type of case and intensity of need. Lead Agency contracts will identify a projected number of children and families to be served annually.
- Emergency Access and Response: The Lead Agency will be responsible for responding to emergency placement and crisis response service needs that arise during regular business hours as well as after-hours.
- Utilization Review: Lead Agencies are responsible for reconvening family team meetings in order to review progress towards the goals identified at the initial team meeting. Utilization review meetings occur no less than quarterly. In between formal meetings, the Lead Agency is responsible for monitoring progress and communicating to the DSS social worker any updates or modifications made to the service plan.

- **Care Management:** DSS will determine which children in or at risk of residential placement will be referred to the Lead Agency for Care Management. Care management is a different, more intensive role than service coordination. There are two key distinctions. First, care managers will be empowered to make a wider range of decisions (as described below) than service coordinators. This broader authority aligns with the greater responsibility for achieving the result of helping families whose children are at risk of or in long-term residential placement to care for them at home. The second distinction is the anticipated lower caseload for care managers. Care managers would work more intensively with fewer families (e.g., 20) than service coordinators (e.g. 60). As with the service coordination role, care managers are responsible for linking the DSS service plan and provider treatment plans.
  - Referrals: DSS will be the source of referral to this level of care management. The Lead Agency will conduct and lead the assessment of alternative services that it could arrange through its network to support families whose children are at risk of or in long-term residential care but could be cared for in permanent family settings. In conducting its review of children and families, the Lead Agency must consult with and build consensus with the DSS social worker and family.
  - Care Management Decision-Making Authority: As with all service coordination decisions, the Lead Agency is expected to build consensus with the family and DSS social worker regarding the opportunity to avoid or return from residential placement. When there is disagreement about a referral to this level of care management, DSS holds final decision-making authority. However, once a child and family are referred, the Lead Agency has the decision-making authority to decide what services are necessary and to work with network providers to develop and manage appropriate treatment plans. The Lead Agency is granted authority to make the some decisions in addition to those listed under its service coordination role.

| Lead Agency Decisions under Service Coordination role | Lead Agency Decisions under Care Management role |
|---|---|
| 1. Selection of specific family based service models, providers, and community resources to work with a family / family member. | All decisions allowed under the Service Coordination (See # 1-5), plus the following: |
| 2. For each family based service, the intensity and frequency of service receipt. | 1. The frequency and location of visitation. (DSS decides whether it must be supervised.) |
| 3. Changes in service providers working with a family / family member. | 2. Short-term trial visit for purpose of transitioning to permanent family. |
| 4. For children in their home, short term respite in out of home settings. | 3. The placement provider, the level of care, and the location (initial and subsequent changes) |
| 5. For each family based service, duration and termination, whether because of success or ineffectiveness. | 4. Determination of type, level, and scope of educational advocacy on behalf of the child. |

- **Level of Service Decisions:** The Lead Agency must use a *Level of Service* decision support tool to guide the service decisions it makes with the family teams (MA has decided to use CANS for this purpose). The first application will be to identify children currently in or at risk of long-term residential placement who might be equally well served at home with the proper services. Ultimately, the guide will be used for identifying the level of a family or community based service for families even when placement is not being considered.[i]
- **Legal Proceedings:** Lead Agency staff must be available for and participate in any legal family-related discussions, hearings, and trials determined necessary by DSS. Lead Agency staff is required to participate in trainings regarding the legal framework for the Department's work.

**Administrative Management Role and Responsibilities**

DSS will provide administrative management to support Family Networks including:

- Automated Information System: Lead Agencies will be required to use the information system(s) provided by DSS to manage their work with families and service networks. When using DSS office space, they will have access through dedicated desktop computers. In order to connect from their own offices, Lead Agencies must have equipment that meets specifications set by DSS.
- Financial Management Systems: DSS will manage contracting, payment, and service budgets through its FamilyNet system. In the first phase of this system (at least), Network Provider contracts will be held directly with and paid by the Department, not by the Lead Agency. Lead Agencies are not expected to build their own financial management systems.
- Performance Reports: As FamilyNet will serve as the case management and financial system of record, it will also be the source of reports on performance and quality.
- Office Space Co-location: DSS Area Offices will support their partner Lead Agencies and Regional Resource Centers by providing office space to use on a "hoteling basis".

## Financing & Rate Specifications

The total estimated expenditure to be made during the life of this procurement is $135M. Estimated expenditures under the initial contract duration are anticipated to be $45M (July 1, 2005 – June 30, 2008).

The Department is using a cost reimbursement compensation structure for these contracts for the first year (at a minimum), with the option to negotiate a different structure at a future date.

The RFR provided a Price Range of $450,000 to $550,000 per Area. Lead Agencies bid within the range.

Start Up & Phased Implementation: The first quarter of implementation for Area Lead Agencies overlaps with the phasing down of current service coordination contracts. The new Area Lead Agencies must take over the relevant responsibilities of the current Family Based Services Lead Agencies, *Commonworks* Lead Agencies, and Boston's FRN Lead Agency at the end of a 3-month transition period (July 1 to September 30, 2005).

Phased Implementation: The first phase of implementation focuses on the residential system. Lead Agencies will provide service coordination or care management to the children and families receiving services through the residential system beginning October 1, 2005. Demonstrated success in this first phase will be the basis for proceeding to the next phase of incorporating the additional groups of programs (e.g., therapeutic foster care, shelter). The timing of these subsequent phases may vary across the state.

Future Year Adjustments: The RFR noted that changes may be made in scope, budgets and reimbursement arrangements in future years.

Flex Funds: Lead Agencies have some flexible funding available to catalyze family involvement. The amount of flex funds allocated per Area Lead may change over time.

## Building the Service Network

DHS will secure contracts for services that will be accessed by the Lead Agency. An RFI has been issued to refine what services will be available. Lead Agencies may also be service providers. A cap, however, is imposed. DSS' review of network referral patterns will trigger intervention when the Lead Agencies' share exceeds 15% of the Area Office's total network service budget.

## Performance Management & Measurement

Although DSS will not implement financial risk / reward sharing in the first year, it will use a case flow model as a framework for tracking performance. First year performance will be measured against FY05 baseline data. Implementing the performance measurement system will allow DSS to determine the specific measures and the appropriate data sources, assess the impact of performance measurement on practice, and establish goals to which each party will be accountable in the following year. In conjunction with performance reporting and accountability, program standards will be established for Area Lead Agencies, Regional Resource Centers, and Network providers. The specific process measures and outcomes are still under development. However, the RFR included *draft* outcome indicators related to safety, permanency, and child well-being for children not in placement and for those requiring placement.

## Contract Monitoring

DSS holds contract monitoring responsibility since it will hold the Lead Agency and Network Provider contracts. DSS will coordinate a process to identify the Area or Region to "host" the contract and will then have lead responsibility for monitoring the Lead Agency contract. They will assemble monitoring teams, which will include the DSS Area Resource Coordinators and Planning & Program Development Division staff. DSS expects that all partners will take a continuous quality improvement and learning approach to any program improvement plan that results from monitoring efforts.

Lead Agencies hold the responsibility and have an incentive for monitoring the performance of providers in their networks. One of the tools they have to influence and incentivize improved performance is referrals. As the main referral source, the Lead Agency must be satisfied with a provider's performance in order continue or increase referrals to them. Preferred provider status is intended for providers whose performance is in the top tier of their peer group.

### Interview With a Family Network Area Lead Agency

The interview is with Joe Leavey, the Executive Director of Communities for People, Inc., one of the largest child welfare agencies in Massachusetts and a recipient of one of the Area Lead Agency contracts.

*What are your main concerns about the new initiative?*

Mr. Leavey's comments focused on five principal areas:

1. Outcomes and Expectations: "While the goal is clearly to move towards a greater focus on family involvement and permanency, with an immediate reduction in the use of residential care, the State has not yet finalized the performance standards or specified the outcomes or results. We have started implementation without a full understanding of expectations."
2. Data Capacity. "In order to implement this Initiative, the State dismantled two contracts with agencies that were previously responsible for data collection, performance monitoring, and reporting for the previous *Commonworks* and Family-based contracts. Instead of outsourcing data collection and reporting, under this initiative, DSS intends to collect and monitor data by building capacity in the State's SACWIS (FamilyNet). There is a great deal of skepticism about how long it will take to build adequate capacity to generate the types of reports that were most useful under prior contracts. While the Lead Agency contracts did include data specialist positions for each Area, it is not clear what data will be collected and tracked."
3. Service Capacity: "The primary goal in the first year is to reduce reliance on residential and group care. Even though the Lead Agency is not at financial risk, the Lead Agency is expected to help DSS achieve that goal. The difficulty is the lack of alternative foster care and community options to support the complex needs of children currently in the more restrictive placement settings. The recently released RFI sets out a plan for beginning to build alternatives to residential and group care through the creation or expansion of intensive foster home care ($180/day with $80 to Foster Parent and $100 for services/supports provided by the foster care agency); and stabilization beds (Residential) for short-term, crisis stabilization/respite or

assessment. Over time, it is clear that children may be able to be diverted from intensive placements but in the short-term, there are limited alternatives available."

4. No Incentives: The lead agency has no risk but there are also no incentives to achieve desired results. CFP was formerly a *Commonworks* Lead Agency. That contract was initially no-risk but after 18 months, the lead agencies were given a case rate, with a monthly payment per child served (the payment was approximately $180/day). They had wide latitude in the use of the funds and were able to tailor services to individual needs. If their efforts resulted in savings, the lead agency was allowed to retain savings and enhance services. In addition, by attaining specified goals, agencies were able to earn bonuses. On its surface, the current contract seems like a giant step backwards, at least in the first year when it is a straight cost reimbursement of approximately $400,000 per Lead Agency solely for care coordination or care management. While the Lead Agencies may make referrals, they will not pay for services or hold contracts with providers or reimburse for services provided. DSS currently spends about $250 million in RTC and $27 million in non-purchase of service contracts, but the lead agencies will not have the authority or financial flexibility to stimulate needed capacity unless DSS agrees that a service is needed and contracts with a provider to deliver it.
5. Service Coordinators, Care Managers and DSS workers. While the current contract is far clearer than the earlier *Commonworks* contracts were, there are still a lot of day-to-day gray areas in terms of who has authority to do what. The lead agencies would much prefer to have full case management responsibility to eliminate duplication and redundancy in the current dual approach. However, that has proven to be an elusive goal. The labor contracts for DSS staff are in place for at least another year. The Union will oppose any attempt to delegate or change any of the work of their staff. The opposition at times makes it difficult to operate. For example, Lead Agencies wanted to get together to develop common forms for Intake and Referral and were told that no such work could happen without Labor's approval since new forms might impact the work of DSS workers.

*What was the impetus for the Initiative?*

There was a perfect alignment of two forces. Critics who argued persuasively that a disproportionate share of the resources were being consumed by residential services were joined by those who have long advocated for more family-centered approaches to practice. The State has over 2500 kids in long-term residential care (at about $380/day). It became clear to all that the number needed to be reduced.

*What should public agencies consider in contracting for case management?*

1. Make sure there is clarity in public and private roles/responsibilities.
2. Make certain that the public agency retains the responsibility for legal services.
3. Include fiscal incentives aligned with results—but make sure you have IT and quality assurance capacity to monitor both costs and outcomes.

*What should private agencies consider in developing the capacity to provide case management services?*

1. Look at this as an opportunity but also recognize what you don't know and hire the people who know case management from the public agency perspective.
2. Look at staffing—recruitment, training, and then build capacity to respond to the public agency's need for immediate responses.
3. Have an attorney on board to review liability issues and prepare the Agency's Board.

*If you had it to do over again, what would do differently?*

I would have fought harder to eliminate the dual system of case mangers and DSS workers. This approach works well in some cases and not so well in others. Too often it comes down to personality or the culture of one Area office versus another. In the absence of clear terms about respective responsibilities, you end up with role confusion —not just for the DSS and private agency staff but also for the children and families.

*What were your greatest "success" and your greatest difficulty with the previous Commonworks and Family Based Contracts?*

1. CFP met expectations. In hindsight maybe they weren't all the right expectations (there was not enough focus on family involvement or permanency) but still we succeeded. I think I am most proud that we expanded service options in the network and increased cultural diversity by recruiting new agencies.
2. The greatest difficulty has been managing an ambiguous relationship with DSS. The public agency does not structure our relationship to build on inherent private agency strengths. Private agencies could (if allowed) innovate, bring in more community support, advocate for more resources for both DSS and the system as a whole, and operate differently from the Department."

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## 2. Missouri-Performance-based Contracts for Case Management Services

### Background

The Department of Social Services, Children's Division released an RFP in April 2005 to procure performance based case management contracts to meet the needs of the foster care population in targeted areas of the state.

Prior to the release, DSS contracted with Mercer Government Human Services Consulting (hereinafter referred to as Mercer) to analyze potential monthly case rates for alternative care case management services for selected counties in the next year and for future years with consideration for foster care room/board and residential treatment services. Mercer provided what they consider an actuarially sound rate range for each Geographic Area for the provision of case management services. The information was included in the RFP as a guide for bidder's to propose their rates.

### Geographic Coverage

Case management services will be provided in three regions:

- Geographic Area 1 includes St. Louis City, and St. Charles, St. Louis, and Jefferson Counties.
- Geographic Area 2 includes Andrew, Buchanan, Clay, and Jackson Counties.
- Geographic Area 3 includes Greene County.

### Target Populations

Children eligible to be referred include:

- Abused and neglected children under the jurisdiction of the Juvenile Court who have been placed in out-of-home care,
- Children of youth under the jurisdiction of the Juvenile Court who have been placed in out-of-home care,
- The families and siblings of the children placed in out-of-home care under the jurisdiction of the Juvenile Court, and
- Out-of-home care providers.

### Scope of Case Management Services

The contractor will provide case management services for referred cases including, but not be limited to, the following services:

- Assessment - the consideration of social, psychological, medical, and educational factors to determine diagnostic data to be used as a basis for the treatment plan.
- Treatment planning - an agreement designed through a mutual process of negotiation between the family case manager, parents or guardian from whom the child was removed, and the juvenile court (if required by the court), setting out those activities necessary for achievement of reunification of the child.
- Placement services - selection of the most appropriate placement resource for children based on the assessment of the child's unique needs and personality and the out-of-home care provider's capacity and skills in meeting those needs.

- Service planning - the provision of any services indicated and needed as identified through an assessment and treatment plan or ordered by the Juvenile Court.
- Permanency planning - determining the permanent plan which best meets the needs of the child.
- Concurrent planning - working towards family reunification while, at the same time, developing an alternative permanent plan such as guardianship or adoption.
- Community resource development - recruitment, assessment, and training of placement resources. It also includes the development of services to best meet the needs of the child and family when they are not readily available.]

Under each of these areas, the contract provides detailed specifications and outlines consequences for failing to meet requirements, including Corrective Actions, loss of referrals, and potential loss of the contract.

**Goals**

- A safe environment and well-being for all children served;
- Timely permanency;
- Reunification of children in out-of-home placements with their family when possible;
- Continuity for the child in out-of-home care;
- Preservation of a child's connection to the family of origin when possible;
- Continuity of the contractor's family case managers assigned to the case until permanency is achieved;
- A child's right to belong to a family; and
- The child's and family's satisfaction with services.

**Qualifications & Staffing Standards for Contract Agencies**

Licensing Requirements – The contractor and/or the contractor's subcontractors must be licensed as a child placing agency.

Accreditation Requirements - The contractor must either (1) be accredited by one or more national accrediting bodies or (2) be a licensed child placing agency that must submit an application for accreditation with one or more national accrediting bodies within three months of the effective date of the contract and must become accredited by a national accrediting bodies within two (2) years of the effective date of the contract.

The contractor must be a public or private not-for-profit or limited liability corporation owned exclusively by not-for-profit children's services providers.

The RFP also detailed qualifications, credentials, training, and staff development plans required for all case management staff and senior managers, including the specific training topics.

Access—The contractor's professional staff must be available to the state agency and out-of-home care providers 24 hours a day, seven days a week**.**

Supervisory Ratios –The contractor's supervisors must not supervise more than seven (7) staff.

Caseloads – The contractor must provide a minimum of one case manager for every:

- Twenty (20) children in out-of-home care
- Thirty-five (35) children under post-placement supervision
- Thirty (30) active adoptive or birth families; or
- A reasonable combination of the above.

**Outcomes**

The contractor is required to meet the outcomes listed below for the original contract period. The outcomes for the renewal options periods will be determined through negotiations with the state agency making the final decision.

***A percentage of children in out-of-home care must achieve permanency*.**

- 32% or more children in out-of-home care under the jurisdiction of one the juvenile courts located in geographic area 1 must achieve permanency.
- 30% or more children in out-of-home care under the jurisdiction of one of the juvenile courts located in geographic area 2 must achieve permanency.
- 24% or more children in out-of-home care under the jurisdiction of one of the juvenile court(s) located in geographic area 3 must achieve permanency.
- 99.43% or more of children in out-of-home care must not have substantiated child abuse/neglect reports with the alternative caregiver listed as the perpetrator.
- 91.4% or more children in the custody of the state agency or under the supervision of the state agency must not re-enter state agency custody or supervision within twelve (12) months of previous exit.
- 82% or more of children in out-of-home care will experience two (2) or less placement settings starting with the contract effective date for the first year or the referral date if the case was referred after the contract effective date during the first year of the contract.
- 82% or more of children in out-of-home care will experience two (2) or less placement settings subsequent to referral in the second year of the contract and thereafter unless the referral was received prior to the effective date of the contract in which case the contract effective date is used.

***Reduce the average utilization days for residential treatment placements by 2%.***

The current average utilization days by geographic area are:

| Geographic Area | Average Utilization Days |
|---|---|
| Geographic Area 1 | 169 |
| Geographic Area 2 | 183 |
| Geographic Area 3 | 170 |

### Referral Process

The contractor must accept any referral. The state agency reserves the right to make no referrals. The state agency has the final authority on which cases will be referred to the contractor. The state agency will refer additional cases throughout the contract period with the intention of replacing cases which are expected to move to permanency until the contractor has met the maximum number of cases stated in the Notice of Award combined with the number which are expected to move to permanency throughout the year.

Random rotation process – The state will refer additional cases meant to replace those moving to permanency in accordance with a random rotation process. Exceptions to the random process include placement of siblings with the same contractor, cases in which the contractor has a past relationship, and re-entries of children within 12 months of permanency who will be reassigned to the same contractor.

Approximately the same number of referrals each month will be made to each provider to replace the children expected to move to permanency. This process will be accomplished through a rotational process whereby contractors will receive a predetermined number of cases each month with the remainder of the cases being assigned monthly to the state agency.

### Disenrollment

The contractor provides case management services to all referred cases until or/unless the following occur:

- The court orders the case to be reassigned.
- The court has terminated jurisdiction over the child in out-of-home care and there has been three (3) months of post-permanency services for those achieving permanency.
- A case has been accepted for enrollment in the specialized case management contract.
- A child or family has filed a grievance against the contractor and requests their case be reassigned.
- Contractor's staff has been involved with an unacceptable incident and the state agency determines it is not in the best interest of the child/family to reassign the case to another of the contractor's family case managers. In such circumstances, the case will not be replaced and the monthly payment will be reduced by the number of cases disenrolled. In addition, the contractor may be placed on referral hold, or the contract may be cancelled at the discretion of the state agency.
- The state agency determines it is in the best interest of the child/family to reassign the case to state agency staff. These situations may include, but are not limited to, those situations when a child in out-of-home care is not moved to a permanent home within a reasonable timeframe.
- In the event the child/family moves out of a county, the case will not be disenrolled and the contractor must continue providing services.

- When a contractor loses referrals due to egregious situations during the first year of the contract, the number of referrals made during any subsequent years of the contract will be reduced by the same amount.

Aut**omated Systems**

Missouri does not have a SACWIS. However, the contractor will have access to the state agency's Children's Division information system (PROD) through Virtual Private Networking (VPN). The State provides the software and the Contractor is responsible for internet service provider and associated costs. (If the State moves to a SACWIS, the Contractor will have the ability to update as requested by the State). The Contractor updates the client record including information regarding, but not limited to, placements, court hearings, and Family Support Team meetings.

**Legal/Court Responsibilities**

The contractor cooperates with the state agency and the Division of Legal Services (DLS) in the preparation for and handling of any legal matter that may arise regarding any child or family receiving services under the terms of the contract. The contractor's family case managers attend court hearings involving the child(ren) for whom they have case management responsibility.

**Financial Arrangements**

Start-Up Funds **–** The contract includes one-time firm, fixed start-up price of no more than $126,000.

Case Management Invoicing – The contractor submits a monthly invoice at the beginning of the month for the number of cases stated in the Notice of Award and additional referral(s) made by the state agency in excess of the number of cases stated in the Notice of Award to keep siblings in out-of-home care with the same contractor. The contractor does not invoice for additional cases assigned through the contract period which are meant to replace the cases of children moving to permanency.

- The contractor reduces the monthly invoice by the number of cases which are to be referred monthly while the contractor is placed on referral hold.
- The contractor does not invoice for re-entries into care within 12 months of permanency.
- For the renewal options periods, the contractor invoices for the room and board and residential treatment in accordance with the fixed price stated in the contract plus any percentage of increase(s) throughout the contract period specified by the state agency due to percentage increases in state agency maintenance or residential payments.

**Reimbursements for Services –** The state agency will reimburse the direct provider of service in the initial year. Room and Board costs will be incorporated into the renewal contracts with Lead Agencies.

## Interview With a Performance-Based Case Management Agency

The interview is with Dick Matt, the Executive Director of the Missouri Alliance, a limited liability corporation with nine equity partners, that holds multiple case management contracts under different Missouri initiatives.

*Can you describe the Missouri Alliance case management model?*

"Before describing the current PBC contracts, it is important to recognize that there are multiple different case management contracts in Missouri, beginning with the Interdepartmental Initiative for Children that the Missouri Alliance has held since October of 1998. It has been extended six times (it has never been re-bid). The contract is expiring in December 2005, and it is not yet clear what the State will choose to do with that contract. In addition to the Interdepartmental Initiative that targets children with serious and complex needs, the State also has a limited number of case management contracts that are not risk-based. And, most recently, the State has launched Performance-based Contracts (PBC). These came about after the designers of the Illinois model spent time working with the State to understand and adapt the Illinois model.

Under the specialized case management contracts that preceded the current PBC contracts, the case managers operated just like the Department staff and the contracts were closely monitored—micro-managed. Those contracts paid about $22.00/day/per case. Those agencies came together with original Missouri Alliance agencies to bid on the new PBC contracts. They were already serving over 150 of the 525 cases that were to be included in this region.

There are currently three PBC contractors, one for each region. The Missouri Alliance has the region that includes the St Louis area.

In each of the Missouri privatized case management models, the RFPs and resulting contracts prescribe the case management system and all contracts contain language about outcomes. The bidder simply follows the path laid out by the RFP. In the PBC the focus is on family involvement and best practice in conducting Family Support Teams, focusing on permanency and using concurrent planning. Each contract specifies the staffing and caseload requirements.

In all cases, the legal services are provided by the States Legal Service Staff but with the case management agency preparing the documents and attending the hearings with legal staff.

The PBC is clear on the roles and responsibilities of the Contract agency. That was not always the case in the Interdepartmental Initiative where there was some role confusion. In the PBC, it is clear that the Contractor's case managers are fully responsible for the specified outcomes. The Department does not have social workers for the cases referred to the PBC Contractor and the Contractor does not have to get prior approval to make placement changes or to change the case plan. The contractor is totally responsible for working with the child and family to achieve timely and safe permanency.

*What was the process for receiving initial referrals?*

In the new PBC contracts the State included start-up funds and allowed the Contractors three months to build the capacity before transferring cases. Then in the first month of

implementation, the agencies received all the cases they had bid. In the case of the Missouri Alliance, we bid 525 cases which are being divided among the partner agencies.

This is brand new. The cases are just now being transferred. The initial group was matched with the caseload that is kept by Department in terms of age, sex, length of stay, prior experience, etc. The match was done to help with the evaluation which will be conducted by the University of Missouri. About 60% of the foster care caseload stays with the Department social workers.

After the initial matching, the state will use random assignment. The case transfer has varied depending on the county—some hold formal case transfer staffings, others have private workers and public social workers meet informally to review cases, still others just send the files. Once accepted, the Contractor is responsible from the time of referral until the child achieves permanency and the case is closed. We are also responsible for ensuring that the permanency is stable. If the child returns within 12 months, we get the case but not additional funds.

*How many cases are you currently managing?*

In the Interdepartmental Initiative, we have between 390 and 400. For the PBC, it is 525. The PBC RFP called for caseload of 1:18 but the Alliance is hoping to keep it at 1:15. The supervisor: case manager ratio is 1:7.

*Is there a direct link between outcomes and payment?*

The Interdepartmental Initiative was a case rate with both bonuses and penalties linked to outcomes. The PBC contracts specify outcomes that are implicit in financing but there are no direct bonuses or penalties.

*What are the funding sources and reimbursement mechanisms?*

In original Interdepartmental Initiative, there were blended funds from Mental Health, Youth Services, Medicaid and Child Welfare. After Mental Health and Youth Services pulled their funding out in 2003, Medicaid continued to provide about 17% of the rate (based on cost of care in 1996). The rate has changed over time with periodic increases. Currently it is about $3800/month per child, with about $475 of that designated for case management which was added midway through the contract. The contract also has performance penalties and bonuses that have remained the same since inception.

The PBC is a staggered implementation. In Year 1, all funds are child welfare; in future years when the Contractors assume responsibility for placement costs, Medicaid (rehab funds) will be used for therapeutic levels of care. Contractors are expected in Year 1 to bill Medicaid for non-placement services that are not included in the rate but the State pays placement providers for placement costs. The PBC does not have explicit bonuses or penalties. But, the risk is clear. The providers continue to receive referrals but the income is fixed at the price specified in the contract. If the provider does not move children to permanency, the caseload increases but the funds don't. To stay in compliance with caseload standards, the contractor would have to hire additional staff with no funds to cover.

In the first year, our rate is about $816/month per case. We are projecting that about half of the costs will go to services for the child and family and the remainder will cover case management and administrative costs. The State was spending about $33 month per case for services so we plan to significantly increase that amount. Each Alliance

agency with case management responsibilities will have a budget and authorization will occur through the Alliance.

*How were the rates determined?*

For the first year of PBC, agencies are paid for case management and non-placement services. In future years, the state will roll in room and board costs. The agencies said how many kids they wanted to serve and the RFP provided a price range based upon a projection of what the state paid for case management and treatment services.

If awarded the contract, the agency gets 1/12 of the payment the first day of the month. If the agency meets the target expectations then they still get the same funds and cases drop. If they do not reach goals, they get more cases but no more money.

There is no mechanism in either the Interdepartmental Initiative or the current PBC to mitigate risk. In both, however, there is front-end funding flexibility and agencies can retain and reinvest any savings.

*Is case management just one of the services you provide in your contract with the Department? If yes, what other services do you provide?*

In the PBC, the Missouri Alliance has some therapeutic foster homes but all case management is divided among the partner agencies. This is the reverse of the model we used for the Interdepartmental Initiative where the Alliance provided almost all case management services (there are about 50 case managers and the Alliance has all but about 6 who are employees of Alliance partner agencies).

*What is the process for authorizing and paying for services needed by the child/family?*

The process to authorize services is fairly straightforward:

1. The Care Manager with the Family Support Team designs a Plan of Care including Goals, Objectives and Services necessary to accomplish the goals.
2. The Care Manager goes to the computer and pulls up "Service Authorization" screens. They begin to enter each service individually. They select the provider from a drop down box which currently lists all the providers under contract for a particular service.
3. They authorize a specific number of units of the service (8 units of Individual Counseling, for example) for the coming month (authorizations only cover a one month time frame). The service must be directly related and identified in the system toward one of the goals.
4. The computer generates a "turnaround" document which functions as the billing invoice.
5. The document is mailed or faxed to the provider.
6. The provider returns the document after the close of the month with accompanying progress notes.
7. The document is then processed within the computer system for payment.

Of course, the actual mechanics are much more detailed but this gives you a good idea of the process.

*Does your organization maintain a network of service providers? If so what services are represented?*

For the Interdepartmental Initiative, over time the Missouri Alliance expanded services and built capacity in needed areas. In the PBC, some of the kids being referred are already being served by agencies outside the Missouri Alliance so they are being added to the Missouri Alliance network.

*Do you have contracts where providers are assured referrals or do you have lists of services and rates paid but with no guarantee of referral? Are rates the same for all your providers?*

Actually, we use both methods. We primarily have contracts with providers which are open ended and guarantee no specific number of referrals. They are very "service" specific rather than "program" contracts with the exception of residential treatment. We have probably 400 such contracts

However, we have instituted a few "guaranteed" contracts for residential care. These were specifically with our equity partners. We redefined what we wanted from a residential placement. We wanted: (1) staff trained in wraparound theory, (2) short term stays, and (3) primary concentration on getting information about necessary treatment to put the child in the community. In other words, it was not a typical "program" as usually conceived by the residential providers. We then guaranteed a certain number of beds that we would pay for even if vacant. We have 2 such programs going now.

We have rates which we view as a maximum. However, they have become the "standard". We will, however, negotiate rates for individual services such as mentioned in the guarantee program, or inpatient psych placement."

*Is there any formal application/credentialing process for your providers?*

Yes, all providers go through a formal application and credentialing process. We are sometimes, however, forced to pay some providers prior to the completion of the process due to the necessity of obtaining immediate services.

*What is your responsibility for monitoring provider performance versus that of the Department?*

The Department has no responsibility for monitoring our providers. We provide all monitoring of their performance and report those to the Department.

*Are you required to go outside your equity partners for services?*

No, we are not required to go outside. However, it becomes a necessity. For the Interdepartmental Initiative, we are currently running at about $18 million a year and the 9 owners cannot produce all of the services which we require because it is such a vast array. In the beginning, the state attempted to push us away from our owners into other providers but there was no contractual requirement. We have significantly increased the use of the partners during the last 3 years. The Missouri Alliance will monitor for PBC outcomes and service provider contracts contain specific requirements.

*What was the impetus for the public agency to contract for case management services?*

The Legislature has increasingly called for expanded privatized contracts. Sweeping mandates have not passed but the PBC contracts appear to be an incremental step. The PBC will undergo an evaluation that should help to answer what works and what doesn't.

*What are the top three issues that public agencies should consider in developing a plan for contracting for case management?*

1. Build a real partnership with the private sector to get the political clout needed for hard times.
2. Make sure the financing option gives flexibility in funding and specifies the outcomes/results desired.
3. Require accreditation as an added protection for quality. (Both the contract agencies and the Missouri Department are required to go through accreditation)

*What are the top three things that private agencies should consider in developing the capacity to provide case management services?*

1. First, they need to build the expertise—start by hiring experts to guide them through all they don't know about the system's obstacles.
2. Get a handle on costs and if the money isn't there—don't bid.
3. Philosophy of care— Many providers will need to embrace family-centered practices, build child/family strengths that will help to achieve permanency, while also acquiring new business tools and skills.

*If you had it to do over again, what is at the top of the list of things that you would do differently?*

1. With the Interdepartmental Initiative, the Alliance should have immediately expanded services to include traditional and TFC to reduce reliance on RTC.
2. Hire seasoned child welfare workers— Initially, the Alliance relied too heavily on mental health folks who did not understand child welfare and who did not bring family-strengths perspective.

*Describe your greatest "success" and your greatest difficulty.*

1. With the Interdepartmental Initiative, the greatest success has been meeting the outcomes of moving kids to lower levels of care. But, one of less successful parts has been not doing that quickly enough.
2. The greatest difficulty has been and continues to be the financing. Take an under-funded state system, increase expectations but not money, and you have problems.

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## 3. Cuyahoga County, Ohio-A Case Rate Lead Agency Pilot for Foster Care

### Background

In 2000, the county launched a case rate lead agency pilot. Notification to awardees and contract negotiations began in December and extended through January 2001. Implementation began in the Spring of 2001. The primary difference between the current system and the pilot is that contracted lead agencies will be expected to:

- Adhere to no eject/no reject policy with a response within 90 minutes of the initial call and placement within 4 hours,
- Provide a foster family within the child's community,
- Work with the birth family when reunification is the goal,
- Concurrently plan for adoption,
- Provide all services needed to achieve permanency,
- Be evaluated on specific performance measures, and
- Take some level of financial risk for each child.

### Goals

The primary goals are to ensure permanency decisions are made within 12 months and have permanency stability with no reentry for 9 months, reduce lengths of stay, improve outcomes and accountability for children and families, improve cultural relevance of services provided, and improve community support by encouraging pilot contractors to link with community-based organizations. (Lead agencies will connect to existing collaboratives created under the Casey Family-to-Family initiative.)

### Population Served

The initiative targets a portion of the county' caseload from birth to age 14 who are in specialized foster care. Only children who have behavioral or health care needs (Levels 2 and 3) and their siblings are included in the pilot population. Each contractor will serve 100 children and families per year in the region of the county they specified in their proposal. It is projected that 168 children will be served in the first 12 months. When fully implemented, each of the three contract providers will serve up to 100 children and families annually.

### Services

- Coordination with CPS intake and investigation
- Assessment, diagnosis, and case management
- Crisis services and emergency shelter
- Home-based family preservation and support services
- Permanency planning with families
- Family and treatment foster care
- Group and kinship care
- Residential care and day treatment

- Inpatient psychiatric hospitalization
- Adoption recruitment and post-adoption subsidies and support
- Outpatient mental health services and substance abuse treatment
- Respite care
- Independent living

### Quality and Outcomes

The contracts with lead agencies include performance standards and explicit outcome indicators in the following areas:

- Access to services
- Use of standard protocols to ensure appropriateness of care
- Accreditation for lead agencies
- Grievance and appeals
- Safety and permanency
- Continuity/stability of placement
- Child and family functioning
- Recidivism/reentry

The contracts require that lead agencies ensure family involvement, including specifying the frequency of contact between the child and family and between the care manager and the family. The RFP also requested documentation of cultural competency, including prior experience with diverse populations, outreach strategies, inclusion of diverse providers in the network, and recruitment of and support for diverse caregivers.

Reports from providers, assessments, and data will be used to monitor system performance and outcomes. In addition, the department is matching the children referred to a control group and will compare outcomes over time.

### Lead Agencies

DCF is contracting with three nonprofit lead agencies. The lead agencies are responsible for contracting with network providers; providing ongoing use management, including prospective, concurrent, and retrospective reviews; handling all case management related to treatment and permanency planning; and collecting data to meet state and federal requirements.

The current lead agencies are Beech Brook, with a case rate of $56,000 for children aged 14 and younger; Catholic Charities Services/Parmadale, with a case rate of $53,000 for children aged 12 and younger; and NBA Cleveland Christian Home, with a case rate of $54,000 for children aged 14 and younger.

### Financial Arrangements

The budget for the initiative in the next first year was $3.48 million. The department estimates the total cost of the 5-year pilot project will be between $13.6 and $17.1 million. The project is fully funded with child welfare funds.

DCF is using an episode of care case rate. The episode begins at the point of referral and ends 9 months after permanency plan, or up to 36 months, whichever is sooner. The payment schedule for contractors calls for 18 equal monthly payments for each client. It is possible that a front-end payment or other prospective payment may be negotiated in the future. If the child achieves permanency and remains stable for nine months, the financial obligation of the contractor ends. If the child reenters care within nine months of permanency, the pilot contractor must take responsibility for the child's care and services from the original case rate.

The contract does not have bonuses attached to performance but there are penalties associated with failing to achieve permanency. The lead agencies serving children aged 14 and younger must achieve permanency within 36 months for 80% of the children served. The lead agency serving children 12 and younger must achieve permanency within 36 months for 87% of children served. For every child over the allowable standard who has not achieved permanency, the provider will be fined $3,600. The case rate for those children will end and the child will be removed from the pilot project but will remain in his or her current placement.

The case rate amount was established through the RFP process. The department offered a range based on current costs for a cohort of similar children, and the bidders specified the rate within the acceptable range. The department estimated case rate costs at approximately $45,000 per child for projects serving children aged 12 and younger and approximately $47,500 per child for projects serving children through age 14. The case rate is designed to cover the period of custody to permanency, plus 9 months (12 months for adoption cases), and assumes that at least 50% of children achieve permanency within 12 months. The actual rates paid under the contract are significantly higher than the department had projected.

Included in the case rate are per diem costs, case management costs, all social services, emergency cash, therapeutic costs not billable to Medicaid, all clothing costs, and administrative costs. The rate is not intended to cover psychiatric hospitalizations or any Medicaid services. Pilot providers may have access to home-based services provided through the department on a limited basis. Medicaid, general revenue funds, and TANF will be used to pay for services outside the case rate.

**Limits on Risks and Savings**

One contractor has accepted full risk; the remaining two contractors have a 10% risk corridor. There are limits on the potential retained savings. The contractors may request that as much as 30% of retained earnings be used for documented, department-approved start-up costs. The remainder must be used based on a joint neighborhood planning process to benefit the community in which the pilot is located and the department must approve the plan.

## Interview With a Lead Agency Operating Under A Case Rate

This interview was conducted with Patricia Varanese, Director of Family Connections at Beech Brook in Cleveland, OH.

*What is the scope of work of your case managers?*

Our Family Connections' case managers do everything the public caseworker would do for similar cases. We receive the case from County Intake. It is our responsibility to place the child or sibling group in a foster home or another relative's home and supervise that placement. We develop the case plan along with the family and present it to the court and county for input. We work on reunification, TPR or adoption, based on the case plan. We also input data into the public IS system, and we are responsible to apply utilization management to all case plans and services. Family Connections has Family Life Specialists who manage aftercare cases and other supportive activities to aid the case managers.

*Describe your case planning process.*

The case manager completes the strength and needs assessment tool and presents this at the first family team meeting to identify necessary services for the case plan. The team gets buy in from the family, DCFS, and others important to the child. The case plan provides direction for working with the family. All case plans are highly individualized, and due to the flexibility of funding, services are tailored to child and family needs.

*Who is the identified client (the child or the family)? How are cases identified in SACWIS?*

The SACWIS system is called FACTS and cases are identified by the family, but Family Connections is paid a case rate per child.

*How is the family involved?*

The family is involved from the first family team meeting. A three level concurrent permanency plan is developed. Plan A is for placement with the parent, Plan B is for custody to go to a kinship family, and plan C is for adoption.

*If the family is actively involved in case planning, describe that process. Does the family "sign-off" on the case plan?*

Parents are involved in case planning and decision making and do sign off at family team meetings.

*What is the case plan review process? What is the role of the court in that process?*

We review progress with the family at monthly team meetings. The court signs off on the initial plan and semi-annual reviews thereafter. We need court approval for all case plans.

*Who represents the family in the legal process?*

Most parents get a court assigned attorney, GALs are assigned for the child, and a public defender or assigned counsel for the families.

*Does the family's legal representative become involved in the case planning?*

The family's legal representative has very little involvement. He or she is more involved in the initial complaint.

*What is the interface with Protective Investigations pre-disposition?*

We get referrals from the Intake worker/PI who has 30-45 days to complete the investigation. Once the transfer to CRPP occurs, the PI is out of the case and an "ongoing" Department Case Manager oversees the case, but has very little to no involvement with the child or family.

*Does the Department also have case managers/service workers? If yes, what is your relationship with those public agency workers? Are the respective roles clearly defined?*

The assigned Department Case Manager oversees the case and sometimes, there are control issues. We continually have to review the roles between Family Connections and the public agency workers, especially with turnover and with new supervisors and caseworkers.

*Does the (state) Department have sign-off on individual case plan decisions, and if so, how does that process work?*

The Department Case Managers do have final sign off, and they receive a monthly packet with reports of case-level activity to keep them informed. The Department Case Manager is invited to family team meetings, but few come.

*Are you responsible for court-related processes?*

We provide input to the Department for the court report. Their lawyers represent CRPP staff [not clear: must be in agreement.]

*Was there a phase in process for referrals?*

Yes, we started with 20 "transition" cases of children who were already in the system at a Level 2 or 3 and then gradually went to intakes of new children to the system.

*Describe the case transfer process.*

Materials were copied and transferred by staff to the CRPP

*At what point in the life of a case do you accept cases? At what point does your responsibility end?*

Our responsibility ends once a permanency placement has been reached plus 9 month of legal aftercare or 12 months for finalized adoption cases. During that time, we keep track of the family and the progress they are making, but the families are not considered active cases for case management.

*What are the caseloads for case managers? What is the ratio for supervision?*

12-15 children for each case manager and a ratio of 4 to 1 for supervision.

*What are the quality assurance/improvement and contract monitoring requirements?*

The contract describes the scope of work, service array, and neighborhood and community linkages. Team meetings need to be held within 7 days and within 30 days, the case plan needs to be developed for approval by the county. There are financial penalties for not reaching permanency within 24 months. If a child comes back into care while still in aftercare, CRPP is still responsible financially.

The Department monitors our contract through outcomes on a quarterly basis and financially on a monthly basis. We have debriefing meetings to review the results with Department staff and their consultant.

*Does the contract set caseload standards?*

The contract does not set caseload standards.

*Is there a direct link between outcomes and payment?*

Payment is capitated and CRPP is at risk. CRPP gets a $5,000 bonus for achieving a finalized adoption.

*What are the outcomes or performance indicators in your contract?*

We are compared to the control group at the county. So far, we have the same or better outcomes. Outcome indicators include: out of home length of stay, length of stay in high levels of care, placing children within their neighborhoods, placing sibling together, non disruptions in foster care, recidivism, and no additional incidents of abuse and neglect. The outcomes and performance standards have stayed the same over time.

*Are there ongoing mechanisms for you and the Department to review performance and problem-solve difficulties?*

We had monthly meetings at the startup and for the first year, then we went to quarterly meetings.

*What are your data collection and reporting requirements?*

Our case managers enter data into FACTS.

*Is case management just one of the services you provide?*

Family Connections covers case management of the child and family and that includes all financial risk for out of home services. We purchase a variety of out of home services on behalf of our clients. Therefore, we have a network to provide services outside of the intensive case management that our case managers deliver.

*Can you determine what the costs and reimbursement are for the case management component of your contract?*

We have a case rate but we are able to determine, through the use of Activity Based Accounting, the true costs of our case management.

*What funding source does the Department use to pay for case management?*

Foster Care funds, IV-E

*Is your payment schedule linked to performance?*

Payment is fully capitated in the form of a case rate. We accept full risk for all the costs of service delivery, including needed foster care, residential care, and family preservation services. Invoices are not paid until all our reports are received by the county.

*How was the rate for case management determined?*

The county proposed a ceiling for the case rate and then in a competitive procurement process, each potential bidder had to develop their own case rate based on utilization data and expenditure data from the county for the previous 3 years.

*Are there any mechanisms in place to protect you against financial risk?*

The only mechanism is that CRPP can ask to have a child reevaluated for appropriateness for the program within 30 days. This step has only been taken twice. With those two children, there were medical issues and one of the children in the family did not fit the criteria. The case was transferred back to the county.

*Are there mechanisms to allow you to retain savings and carry over to next FY?*

Yes, we can retain savings, but we are required to share the savings with the county for anything over 10% ( minus startup costs) of the final savings. We have been able to carry our share of the retained savings over to the next FY.

*Have the rates or payment mechanisms changed contract?*

Yes the case rate has been reduced from $56,251.00 to $52,500 due to county financial short falls.

*Does the Department have any contingencies on the funding contract?*

Yes, specific to adoptions, the money that the county has to provide bonuses to us for finalizing adoptions is dependent on the Adopt Ohio Act and funding.

*What is the process for authorizing and paying for services needed by the child/family?*

The case managers recommend services and the Director authorizes payment for the services. The Director knows the utilization targets and is able to measure performance against the targets.

*How do the case managers know what services are available?*

We have a network of providers and all case managers have a list of the network providers and can decide which providers offer the appropriate services.

*How do your case managers get feedback from the service providers?*

Through monthly updates, written and phone calls, or meetings.

*Do you have a formal process for disputes?*

Our provider manual and provider contract defines a resolution process to discuss case differences.

*How was the network developed?*

Initially, the network was developed for inclusion into the RFP process, based on what we thought we would need to provide case management services, and out of home services, including foster homes, residential treatment, family preservation, mentoring, and emergency placements. Once we became operational, we tended to use the more successful providers.

*Does your organization have contracts with the service providers?*

Yes we have written contracts which were patterned around a combination of managed care provider contracts and the current county contracts with providers.

*How are service providers held accountable for the services they deliver?*

If we have a problem in the delivery of service from a provider, we meet with them and make suggestions for better services. If the provider does not make the necessary changes, we may not use them in the future.

*Were there any restriction on the amount or types of other services you could provide?*

This has not been an issue. We purchase service from a broad provider network and if our sponsoring agency does not always offer the most effective service, we use other providers.

*What was the impetus for the public agency to contract for case management services and what have the results been?*

The previous Director of the Department of Children and Family Services and the Alliance (provider group) promoted the idea of capitated child welfare through joint meetings, CWLA training, and outside consultants. This process was more provider-driven than public agency-driven.

*Has the initiative undergone any independent evaluation? If yes, by whom and is there a written report?*

Tracy Fields of the Human Services Institute did a concurrent review and evaluation for the Department. We would meet quarterly to review our progress and outcomes. However, a final written report has not been completed.

*If no independent evaluation has been conducted, what other methods are used to track and report "success?"*

The consulting firm of Human Services Research Incorporated has been the consultant for the county in the development of this project and monitors the results on a quarterly basis.

*What are the top three issues that public agencies should consider in developing a plan for contracting for case management?*

- Getting "buy in" from all levels of the public agency staff. The public and private agencies need to have a mutual understanding and agreement of the goals and direction of the project.
- Clearly defined roles and responsibilities between the county staff and the case management organization need to be communicated and understood by all.
- Have to have mechanisms to avoid and manage the risk of abuse and neglect of children while in the system.

*What are the top three things that private agencies should consider in developing the capacity to provide case management services?*

- Make sure that they have enough referrals that fit the project criteria—Is the target population big enough?
- Understand risk. Risk can be created by actions outside of the control of the case manager (ie: court, school).
- Make sure they have the services that will meet the needs of the population that will be included in the project, including enough appropriate foster homes.

*If you had it to do over again, what is at the top of the list of things that you would do differently?*

- Build a stronger relationship with the public agency and consider co-location.
- Have regular meetings on a monthly basis with top and mid level managers to work through all the issues.

*Describe your greatest "success" and your greatest difficulty.*

- Our greatest outcome is the results for the children and families (i.e.: siblings placed together, length of stay is shorter, lack of disruptions, and recidivism and lack of re-abuse and neglect).
- Our greatest difficulty has been contracting problems and ensuring a smooth relationship and quality services from the sponsoring agency.

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## 4. Florida-Statewide Privatization of All Child Welfare Services (Global Budget)

Privatization of child welfare services in Florida began in 1996 when the state legislature required the Department of Children and Families (DCF) to establish pilot programs in which community-based agencies would provide child welfare services through contracts with DCF. Four privatization pilots subsequently were established. Following the implementation of these pilot programs, the state legislature, in 1998, mandated statewide privatization of child welfare services. An extensive planning process ensured and the transition to a privatized system began in 2000. In recent months, the final service contract was awarded to the lead agency in District 11 (Miami-Dade County). The statewide implementation is now complete.

Over time, the term "privatization" came to be replaced with the term "community-based care (CBC)." CBC refers to the development and implementation of a system of care in which private providers, acting in collaboration with community stakeholders, provide all child welfare services post investigation; there is flexibility in how those services are provided; and efficiency is expected in all aspects of service provision, particularly in relation to fiscal management. Included within the concept of community-based care are a "child-centered" orientation and the delivery of individualized services to meet families' needs through a "wraparound" approach.

The State has service contracts with twenty lead Community Based Care (CBC) agencies, covering all regions of the State. Some CBCs have been operational for almost four years while a few are just beginning the incremental phase-in of all cases. A few CBC agencies were previously single agency service providers (such as the YMCA in Sarasota), but most are newly formed entities created solely for the purpose of bidding on the CBC Invitations to Negotiate. Many CBCs were formed by 4-5 (or more) community service providers who had a vested interest in making certain that the CBC agency would meet the needs of local children and families and fully engage the agencies that serve them. Typically, the founding partners had a seat on the Board of the CBC and also became service providers. More recently, the State has required that the equity partners step off the Board after the contract is awarded to eliminate conflict of interest or perceived conflict.

The CBC transformation has undergone a series of evaluations at every stage of implementation. The Louis de la Parte Florida Mental Health Institute (FMHI) at the University of South Florida, has been under contract with the Department of Children and Families since September 2002, and has conducted an annual statewide evaluation of CBC. The most recent report includes data from 11 lead agencies (28 counties) implementing CBC in FY2003-04. [ii]

The following description of the implementation of community-based care in District 14, Heartland for Children (HFC) is illustrative of the implementation of community-based care; however, it is important to recognize that CBC agencies have had highly varied experiences in planning for and implementing community-based care across different counties and Districts. As a result of the variability, it is not possible to present a uniform picture of the implementation of privatization statewide. The experience of HFC is not intended to reflect the Florida's initiative overall, but it is illustrative of the complexity of the task. HFC is also widely recognized for its approach to quality assurance/monitoring and its prevention focus.

## Interview With a Florida Community-Based Care Lead Agency

For consistency, should these names appear here? Marcie Biddleman, President of HFC or Kathleen Cowen, Vice President of HFC
The responses to these questions are based on interviews with Heartland for Children (District 14- Lead Agency Community Based Care) as a system administrator. HFC contracts case management to four separate non-profit organizations.

*Describe your case management model.*

Heartland for Children offers flexibility in allowing each case management organization (CMO) an opportunity to design a unique approach to case management while accomplishing the same desired outcomes and results. Heartland requires each case management organization to embrace a wraparound approach to case planning and service delivery. Case management models include the Family Team Conferencing Approach and a "team" approach to case management (both case managers familiar with the client).

The role of the case manager replaces the public agency case manager. The HFC case manager's specific role is to gather and assess information about the family. This assessment includes identification of the family's problems, strengths, available resources, service needs (case plan) and treatment strategies. The case manager has to continually assess the results of interventions ensuring that appropriate decisions are made regarding child safety, the risk of future abuse, and the family's accessibility to existing resources to meet current and future needs (prevention).

The case manager is required to have regular contact with all family members to include a minimum of a monthly face to face visit with the child receiving services in the child's home environment. The case managers are required to document all case related activities, provide required information to the court (if applicable), consult with other treatment professionals, supervise visitations, provide transportation services and meet other outcome measures that drive timely permanency (reunification within 12 months of initial removal).

The Family Support Worker supports the case manager by providing some clerical support and assisting in transportation of children to scheduled visits and appointments. The Family Support Worker can also be involved in tracking certain outcome measures (i.e., timely submission of court reports) and other duties that would assist the case manager, including taking photographs of children and supervising visitations if determined appropriate.

*Describe your case planning process.*

The case planning process involves meeting with the client and jointly identifying safety concerns and creating a plan to assure child safety. The case manager plays a very important role in determining both the formal and informal services and resources available to and needed by the family, addressing the changes that need to occur to ensure child safety and arranging for service provision. This case planning process includes negotiating specific goals with the family, negotiating specific dates and prioritizing needs in an effort to develop a realistic case plan.

*Who is the identified client (the child or the family)?* Both. *How are cases identified in SACWIS?*

By the mother's name (Last Name, First Name)

*How is the family involved?*

The family is involved in the assessment process to help identify family problems, assess family strengths (including external supports). The family participates in the service planning and service provision process. This can be done informally in the family's home residence, utilizing a family team conferencing approach or through a judicial mediation.

*If the family is actively involved in case planning, describe that process. Does the family "sign-off" on the case plan?*

The family is encouraged to sign the case plan after it is completed. Although signing the case plan is not an admission to the allegations identified in a dependency petition, some parents are encouraged by defense counsel not to sign the case plan until after the Adjudicatory Hearing (Trial). The case plan must be developed within 60 days of removal or by case disposition (whichever comes first). If the parent does not sign the initial case plan, the case manager is encouraged to file the case plan in an effort to meet the judiciary timeframes without an actual signature. As additional information is gathered on the family through the assessment and case planning process, the case manager is required to amend the case plan as determined appropriate.

*What is the case plan review process?*

The case manager has to make every effort to provide defense counsel with a copy of the case plan prior to submission of the document to the Court. During the judicial proceeding, the Court will review the information contained in the Case Plan and will remove and/or add information as determined appropriate. If no revisions are necessary, the Court will approve and accept the case plan.

*Who represents the family in the legal process***?**

If a child is removed from the custody of a parent, the parent has a right to legal representation. If a parent can not afford legal representation, an attorney is appointed by the Court. The appointed attorney is required to represent the parent during the legal process. The family's legal representative becomes involved in the case planning.

*What is the interface with Protective Investigations pre-disposition?*

Completion of the Pre-Disposition report is a joint responsibility between the child protective investigator (CPI) and the case manager. The CPI completes the initial three sections of the pre-disposition report which captures information on the family's response to the child abuse allegations, prior abuse history and efforts to prevent removal. The case manager completes the remaining sections of the pre-disposition report which involves the social history data and recommendations for disposition.

*Does the Department. also have case managers/service workers? If yes, what is your relationship with those public agency workers?*

The Department has child protective investigators. The role of the case manager has been totally privatized.

*Does the Department have sign-off on individual case plan decisions? If so how does that process work? If not, how do you keep public agency informed?*

No, the CBC has total responsibility. The Department monitors through outcome measures. The State requires that children are safe, their well-being needs are met and they achieve timely permanency. Outcomes are measured through quality assurance monitoring.

*Are you responsible for court-related processes?*

Yes, as the lead agency, Heartland provides oversight regarding the timely submission of court documents and appropriate representation of clients during the judicial process. Heartland is also involved in assisting with judicial barriers that may delay the dependency process (role of Court Liaison) and addressing systemic issues to include implementation of best practices to improve efficiencies. The Department employs all of the Child Welfare Legal Service attorneys that represent case managers during the dependency process.

*Was there a phase-in process for referrals?*

Yes. HFC phased-in case management services over a six month period by case management organizations. Prior to the transfer of files and cases, the organization conducted a 100% review of case files.

*At what point in the life of a case do you accept cases?*

When a CPI makes a determination that a family is in need of case management supervision, the case is scheduled for an early service intervention staffing. It is at this staffing that a case is officially accepted. The case managers remain involved with a case until the goals and objectives of the case plan are achieved or there is some other acceptable reason for termination of supervision (i.e dismissal of the case in Court, family refused services, the family relocates). A case cannot be closed until the case manager evaluates the family's progress and makes a determination that the risks that led to the initial involvement have been sufficiently reduced to ensure child safety. When custody of a child is returned to a parent, the case manager must remain involved for a minimum of six months before a recommendation can be made to the Court to terminate services.

*How many cases are you managing at any one time?*

Caseloads are calculated by the number of children receiving services. On average, Heartland provides services to approximately 3400 children.

*What are the caseloads for case managers?*

Approximately 26 kids.

*What is the ratio for supervision (supervisors: case managers)?*

Approximately 1:6.

*Did the RFP/contract include performance standards?*

Yes, the contract has 16 performance standards. Many directly reflect [CFSR Outcome items that cannot be negotiated. The standards are as follows:

1) At least 95% of the children served shall be protected from child abuse and neglect. (Source: CFSR, Safety Outcome)

2) No more than 1% of children served in out-of-home care shall experience maltreatment during services. (Sources: CFSR national standard, Permanency)

3) At least 95% of children served shall be safely maintained in their own homes whenever possible and appropriate. (Source: CFSR, Safety Outcome )

4) The percentage of children entering out-of-home care who are re-entering care within 12 months of a prior reunification or release to relatives shall not exceed 8.6%. (Source: CFSR national standard, Permanency)

5) The percentage of children reunified who were reunified within 12 months of the latest removal shall be at least 76.2%. (Source: CFSR national standard, Permanency)

6) The percentage of children with finalized adoptions whose adoptions were finalized within 24 months of the latest removal shall be at least 32% (Source: CFSR national standard, Permanency)

7) At least 95% of children served shall have permanency and stability in their living situations (Source: CFSR, Permanency)

8) No more than 49.52% percent of children in out-of-home care on June 30, 2005 shall have been in out-of-home care 12 months or more. (Source: Department Priority)

9) The continuity of family relations and connections shall be preserved for at least 95% of the children served. (Source: CFSR Permanency Outcome)

10) At least 200 adoptions shall be finalized during state fiscal year 2004-05. (Source: Department Priority) -- The number of adoptions in this measure varies from CBC to CBC.

11) a) At least 65% of children in non-TANF out-of-home care will be eligible for Title IV-E; b) At least 80% of children receiving TANF out-of-home and in-home supports will be eligible for TANF. (Source: Department Priority)

12) At least 95% of families shall have enhanced capacity to provide for their children's needs. (Source: CFSR, Well-Being Outcome)

13) At least 55% of adults whose child welfare case plans require substance abuse treatment shall have documentation in the case file that the adult completed treatment or was actively receiving treatment at the time of the review. (Source: Department Priority)

14) At least 95% of children served shall receive appropriate services to meet their educational needs. (Source: CFSR, Well-Being Outcome)

15) At least 95% of children served shall receive adequate services to meet their physical and mental health needs. (Source: CFSR, Well-Being Outcome)

16) 100% of children under supervision who are required to be seen each month shall be seen each month. (Department Priority; also CFSR Well-being Outcome)

*How does the Dept. monitor your contract?*

HFC's first DCF monitoring performed by the district contract performance unit was held in May 2004 and was a desk review. The second review performed by the department's

contract oversight unit is scheduled for November 2005 and will have an on-site component. HFC provides several reports in accordance to the terms of the contract with the department. On a monthly basis, reports include a Child Protection Staff Roster. On a quarterly basis, HFC provides a Training Report and a Locale Improvement Plan report. Annually, HFC provides an Adoptions Incentive Funding Report. A summary of required reports are listed below by frequency and process.

| **Report Title** | **Frequency of Report** | **Submit to** |
|---|---|---|
| Tangible Personal Property Inventory | Must be completed for initial transfer of equipment, and annually thereafter. | Contract manager |
| CBC Personnel Report | Monthly; 10th calendar day of the month for prior month | Contract manager |
| Child and Family Services Report Tool | Monthly; 5th calendar day of the second month in which services were delivered | Contract manager and www.teamfla.org/databases.html |
| Family Support Matching Report Tool | Monthly; 5th calendar day of the second month in which services were delivered | Contract manager and DSFSM@DCF.state.fl.us |
| PSSF Activity Log | Monthly, 5th calendar day of the second month in which services were delivered | Contract manager and Central Office Pr. Mngr- Maria_L_del_Riesgo@dcf.state.fl.us |
| Adult-Adolescent Parenting Inventory | Web based instructions | Contract Manager |
| PSSF Match Funds Reports | Monthly; 5th calendar day of the second month in which services were delivered | Contract manager and Central Office Pr. Mngr.- Maria_L_del_Riesgo@dcf.state.fl.us |
| Child & Family Services Annual Progress and Service Report | May 15th, 2005 and annually thereafter, on May 15th. | Contract manager and www.teamfla.org/databases.html |
| Child & Family Services Plan | May 15, 2009 and every 5 years thereafter | Contract manager and www.teamfla.org/databases.html |
| State Child Access Program Survey | Quarterly, 10th calendar day after the end of each quarter. | Contract manager |
| Local Program Improvement Plan Report | Quarterly, 10th calendar day after the end of each quarter | Contract manager |
| Report of Trust Fund Totals by Client | Quarterly | Contract Manager |
| Independent Living Spending Plan Report | Monthly; 20th calendar day of the month for prior month. | Contract Manager |

| Report Title | Frequency of Report | Submit to |
|---|---|---|
| Child Protection Staff Roster | 1. Initial List of Staff<br>2. Monthly updates Staff List | Contract Manager and Child Welfare Training Unit Administrator – |
| Prevention Expenditures | Quarterly, 10th calendar day after the end of each quarter | Contract Manager |

*Does the contract set caseload standards? If so, what are they and on what were they based (i.e., national COA standards, or others)?*

No, the contract does not set caseload standards. The contract specifies that there is a no-eject or no-reject policy and the provider shall deliver a comprehensive array of foster care and related services to all eligible children and families in the following county or counties: Polk, Highlands and Hardee. Services include, but are not limited to: family preservation, independent living, emergency shelter, residential group care, foster care, therapeutic foster care, intensive residential treatment, foster care supervision, case management, post-placement supervision, permanent foster care, family reunification and adoption services.

*Is there a direct link between outcomes and payment?*

No, there is not a direct link between outcomes and payments between the Department and HFC. HFC has entered into a cost reimbursement contract with the department. The department reimburses allowable expenditures incurred in the delivery of services that are provided in accordance with the terms and conditions of this contract under the global budget. HFC contracts with four case management organizations. The current method of payment for case management agencies is a fixed price contract. Plans are in place to change the method to a unit rate contract.

*Have any of the performance standards or outcomes changed since the contract was first signed?*

Yes, the performance standards have changed since the contract was signed. All changes were formally negotiated. The first set of measures relied very heavily on the Child Welfare Integrated Quality Assurance (CWIQA) reviews. Measures were removed and replaced with measures that more specifically addressed the underlying elements that would have comprised "substantial conformity" in the specified CWIQA domains.

It must be noted that the current performance measures are currently being renegotiated for the current fiscal year's contract. There is a statewide initiative to re-engineer the quality monitoring process, including a dramatic revision of contract performance measures. The new measures have not yet been approved. The list of proposed measures is as follows:

Percent of children not abused or neglected during services

Percent of child investigations commenced within 24 hours.

Percent of foster children who were subjects of reports of verified or indicated maltreatment.

Percent of victims of verified or indicated maltreatment who were subjects of subsequent reports with verified or indicated maltreatment within 6 months.

Percent of children reunified who were reunified within 12 months of the latest removal

Percent adoptions finalized within 24 months of the latest removal.

Percent of child investigations from an entry cohort completed within 60 days.

Percent of child victims seen within the first 24 hours.

Percent of initial Child Safety Assessments (CSA) submitted within 48 hours

Percent of adults in child welfare protective supervision who have case plans requiring substance-abuse treatment who are receiving treatment

Percent of children in non-TANF out of home who are eligible for Title IV-E

Percent of adoption goal met

Percent of children who age out of foster care with high school diploma or G.E.D.

Percent of children who age out of foster care who are working or in post-secondary education.

Rate of children who are missing per 1,000 of children in home or out of home care.

Percent of school days attended.

Percent of children placed within same school zone after removal

Percent of children removed within 12 months of a prior reunification.

Percent of children who achieved alternate permanent placement 15 of 22 months when reunification is not an option.

Percent of children with more than 2 placements within 12 months removal.

Percent of in-state children in active cases (both in-home and out of home) seen monthly

The algorithm by which compliance on these measures is to be calculated has also been at the root of the re-engineering process. There has been a deliberate shift away from point-in-time and exit cohort measurements toward entry cohorts with longitudinal analysis. There has also been much discussion regarding measures with built-in disincentives, such as the measure requiring a certain percentage of completed adoptions to be completed within 24 months.

It is not anticipated that all of the measures listed above would become part of the CBC contract as many of them relate to the Protective Investigations function. Additional information regarding current and potential future measures may be found at the Florida DCF Performance Dashboard at http://dcfdashboard.dcf.state.fl.us/.

*Are there ongoing mechanisms for you and the Department to review performance and problem-solve difficulties? If so, what are they?*

Yes, HFC has a strong QA/QI Plan that involves both quantitative and qualitative measurement instruments to assess quality in an ongoing basis. Ongoing processes include:

The DCF Zone reviews HFC twice annually using the Child Welfare Integrated Welfare Assessment (CWIQA) case review instrument.

To complement the Zone's reviews, HFC requires each CMO to use a statistically abridged version of that same instrument to review at least two cases per month. CMOs use these reviews as supervisory reviews for those cases. HFC then validates two of those reviews for each CMO on a monthly basis. These validations are intended to assure that a) the reviews are being conducted as required, and b) the CMOs are appropriately applying the review instrument at the supervisory level. This helps to enhance understanding of performance expectations among front-line managers and provides HFC staff with a first-hand view of the quality of case management. The statistically abridged version of the CWIQA, originally developed by D14, has been acknowledged as a valuable asset and has been redesigned by a statewide workgroup for implementation at the state level.

HFC conducts 10 Home Visit Follow-up Surveys each month. Those surveys are conducted telephonically with caregivers after Home Safenet reflects that a monthly visit has been conducted. The follow-up survey addresses the regularity and purposefulness of visits, and provides caregivers with an opportunity to voice any concerns with case management or lead agency oversight. The fact that surveys are regularly conducted by the lead agency reinforces to Case Managers the requirement for effective home visits. This survey instrument and process has been acknowledged at the state level as a "best practice."

HFC conducts 10 Foster Parent Satisfaction Surveys each month. These surveys are conducted telephonically. The purpose is to provide an ongoing assessment of foster parent satisfaction with case management and lead agency oversight, as well as to provide foster parents with an opportunity to voice any concerns.

HFC requires customer satisfaction surveys from its subcontractors. This helps to assure that services being offered are meeting the needs of the clients and that they meet quality standards.

Quarterly, the HFC Executive Director meets with the Executive Director of each CMO to review an Executive Management Report. This report reflects each CMO's performance on key performance measures. This assures consistent attention on critical performance factors at the highest levels of management within the partner agencies.

Every Monday morning, the Lead Agency conducts a conference call with Program Managers, any CMO staff or supervisors invited by their Program Managers, DCF management team members, the HomeSafenet representative, a Protective Investigations representative, CWLS, Coordinated Child Care representative, to discuss key performance measures for the preceding week. These key measures include number of children seen, adoptions finalized, cases closed, children reunified, and caseload census. In that meeting, emergent issues that impact on those data elements

are discussed. This allows for the immediate application of interventions before small issues become significant performance problems.

Operations Workgroup Meeting: Every other Wednesday, Heartland's Management team meets with managers from DCF and Case Management organizations as well as representatives from Economic Self Sufficiency, Child Welfare Legal Services, Protective Investigations, Coordinated Child Care, Agency for Persons with Disabilities , Substance Abuse and Mental Health and key providers. In those meetings, issues that affect the network as a whole are surfaced. These meetings also allow for an exchange of information among entities whose scope of responsibility impacts upon the same group of children and families.

CMO Workgroup Meetings: On alternate Wednesdays, the Program Directors and HFC management team meet to discuss issues that impact only at the CMO level. These meetings are truly working meetings wherein problems are addressed and resolutions are achieved through a cooperative and synergistic effort.

Budget Meetings: On a monthly basis, the senior management team from HFC meets with the contracts and budgets staff from DCF to review performance from a fiscal perspective.

*Do your case managers enter data directly into the SACWIS?*

Yes, Case Managers currently enter directly into HomeSafenet, which is the state's SACWIS system. As the system evolves, Case Managers will be responsible only for entering Chronological Notes (Case Notes). Other data entry functions will be completed by a Data Services department comprised of data entry specialists.

*Is case management just one of the services you provide?*

No, the organization is contracted to provide a total array of services to include but not limited to: independent living services, emergency shelter, residential group care, foster care, relative care giver assistance, therapeutic foster care, intensive residential treatment, foster care supervision, case management, post placement supervision, permanent foster care, family reunification, prevention and adoption services.

*Can you determine what the costs and reimbursement are for the case management component of your contract?*

No, the contract does not specifically breakout the cost of case management.

*What funding source does the Department use to pay for case management?*

A variety of funding sources are used to cover the cost of case management. The funding sources include: state funds, Temporary Assistance to Needy Families (TANF), SSBG, Title V-E, Title V-E Foster Care, Title V-E Adoptions, Title XIX Medicaid, CAPTA, Independent Living, and Safe and Stable Families.

*Is your payment schedule linked to performance? If yes, how?*

No, payment is based on a cost reimbursement contract. The department agrees to reimburse the provider for allowable expenditures incurred in the delivery of services that are provided in accordance with the terms and conditions of this contract. Payment is linked to the proper expenditures by budget entity.

*How was the rate for case management determined?*

The contract award was based on the selected recipient of providers submitting proposals for the Initiation to Bid (ITN). The department utilized the services of experts within the department and community for the evaluation and selection of the lead agency. The proposed cost of service was not included in the decision of the Community Based Care provider selection. The rate was determined after the selection of the lead agency through the submission of a proposed budget with supporting information which was negotiated between the Department and the organization.

*Are there any mechanisms in place to protect you against financial risk?*

Yes, the contract stipulates various mechanisms to protect against financial risk, including:

Unanticipated Increase of Individuals Served - In the event there is a 10% increase in either the number of new in-home services clients or new out-of-home services clients, the department/provider will initiate a review to assess performance utilization level. The performance contract utilization review will determine the number of children to be served based upon a projection of clients served both in-home and out-of-home. In certain cases, providers may serve more cases than has been projected. In circumstances where factors outside the provider's control and the provider is able to document that the provider has used all funds appropriated by the legislature, the provider may be eligible for additional funds.

Dispute Resolution – Contract terms define a mechanism to resolve disputes at the lowest level. In the event the representatives' good faith efforts to resolve the dispute fail, other levels of resolution are defined.

Fidelity Bond - The organization maintains a fidelity bond from a surety company licensed to do business within the State of Florida issued by a Florida licensed agent to ensure against any losses or mismanagement.

Fiscal Monitor – The Department is in the process of contracting out the services of a fiscal monitor. The fiscal monitor will provide financial oversight and ensure integrity regarding the CBC Lead Agency's fiscal operations. This includes monitoring adherence to generally accepted accounting principles, but also federal and state regulations regarding the appropriate use of the various funding streams included in CBC contracts.

*Are there mechanisms to allow you to retain savings and carry over to next FY?*

No. All funds earned are based on cost reimbursement.

*Have the rates or payment mechanisms changed since you first signed the contract?*

HFC has been awarded equity funds which has increased the value of the contract.

*Do your case managers authorize services for payment or just refer for services?*

Case managers are not responsible for the approval or authorization of services. Case managers are responsible for making service referrals. Authorization of service payment is provided by Heartland for Children's Utilization Management Unit.

*If someone else authorizes service payment, what process is used?*

Authorization of service payment is provided by Heartland for Children's Utilization Management Unit (hereafter referred to as UM). The goal of the UM unit is to promote child safety and ensure the least restrictive, most appropriate array of services while moving the child and family towards the goal of permanency. UM specialists possess the authority to approve (not deny) services. They ensure triage and referral decisions that require clinical judgment are made by a qualified professional. The use of service dollars is closely reviewed by UM specialists in an effort to ensure both the child and family receive the right services, at the right time and in the right amount. The UM specialists oversee the screening process to determine the necessity of requested services. They evaluate the rationale for services, assessments of current placement, case plans and need for additional evaluations through the consideration of the child/family's circumstance and the provider's ability to meet the service need or provide alternate settings. They collect data for preauthorization and concurrent review. UM specialists routinely analyze all data collected to detect under- and over-utilization of services and recommend appropriate interventions. Case management has access to many services providers through the web site www.heartlandforchildren.org.

*How do the case managers know what services are available?*

Many of the available services are identified at each staffing process (Child Protection, Early Services Intervention, Permanency, Multidisciplinary, and Community Resource Staffings). At the Early Service Intervention Staffing, there is an expert panel of treatment professionals who utilize their clinical expertise and knowledge of the child welfare system to review and assess the service intervention needs of the child and family. Treatment professionals are also available during the other staffing processes outlined above. In addition to the staffing process, the UM Specialist works directly with the case manager to assist in the identification of needed services and appropriate interventions. The UM staff utilize an internal Service Inventory database (stores information on services and providers in the community) as a guide to identifying necessary services in the tri-county area. During the triaging process with the case manager, the UM Specialist will approve and authorize the appropriate service so that the case manager can make the necessary referrals.

*How do your case managers get feedback from the service providers?*

The service providers are required to provide written progress reports to the case manager regarding the family's receptiveness to services and their progress towards completion of the treatment goals.

*Do you have a formal process for disputes?*

Heartland for Children designed Policy 1300-06 to resolve conflicts related to the level of service intervention identified for the child and family. It is the policy of Heartland for Children to participate fully with the Department, contracted providers and others to evaluate children and families, assess risk, identify strengths and needs of the child and family and create an appropriate array of services to expedite permanency. HFC strives to expeditiously resolve any and all conflicts that may arise as a result of the identification and/or authorization of services.

When the conflict resolution policy has been initiated, it is the intention of HFC to err on the side of child safety, rendering an immediate temporary resolution until a thorough

review can be completed and a less restrictive or more intense array of service intervention is recommended. This procedure is applied whenever a HFC contracted provider, DCF representative or other party involved with a case identifies a concern or disagrees with the service intervention recommended for a child and/or family. If a service authorization is denied by Utilization Management, the CPI and/or CMO counselor (hereafter referred to as complainant) will re-staff the case with their supervisor. If the supervisor agrees that the service is necessary, the UM specialist will be contacted via phone or in writing regarding the concern. The UM specialist and CMO supervisor will attempt to resolve the concern through case discussion. If after a thorough review of the presenting concerns the parties are unable to reach a consensus, the case will be referred to the next level of review.

The next level of review will be conducted by the Assistant Director of Operations (who oversees programmatic functions) and CMO Director. Within 48 hours of the noted concern, the Assistant Director of Operations and CMO director will conduct a joint review and/or informal staffing to discuss case dynamics. The Assistant Director of Operations will chair the Level 2 review process and may include other parties as deemed necessary. If after a thorough review of the facts the parties are unable to reach a consensus, the case will be referred to the next level of review. The complainant will have five business days from receipt of the committee's recommendation to outline any additional concerns and/or comments during Level 3 of the review process. All concerns must be addressed to the attention of the HFC Assistant Director of Operations. Upon receipt of the complainant' s additional concerns, the HFC Assistant Director of Operations will forward information to the Executive Director of HFC who will render a final decision/recommendation within one business day of receipt of the compliant. The final recommendation must be documented in HSN and included in the hard copy record.

*How was the HFC network developed?*

Initially the network was developed though existing contract arrangements the Department had in place with area providers. Since the transition, the network has been developed to secure the services of new providers. Techniques used to develop the provider network include: community meetings, news articles, commercials on local stations, development of the website www.heartlandforchildren.org which allows for prospective providers to enroll, expansion of new services with existing providers, word of mouth, hosting of an annual conference and trade show, open bi-weekly operations meetings, provider visits, networking with other community based care agencies, formal request for proposal initiatives and word of mouth.

*Does HFC have contracts with the service providers? If so, please describe.*

The organization currently has two documents templates for purchase of services: sub-contracts and rate agreements. Documents are individualized to the provider providing the service and the service to be purchased. Terms of the sub-contracts include: services to be provided, provision of services, deliverables/performance standards, method of payment and special provisions.

*How are service providers held accountable for the services they deliver?*

It is the responsibility of the Network Development department to monitor the effectiveness of each of the service contracts executed. Monitoring consist of on-site

review of fiscal, personnel, services delivery and compliance with performance measures. The review process includes: preparation of the monitoring tools, scheduling of the review, entrance interview, on-site monitoring of records, interviews with staff and consumers, analysis of findings, exit review with the provider and completing a monitoring report with findings. Plans of corrective actions are required for items found to be out of compliance. Technical assistance is provided by the contract team and organization program specialists.

*How do you prevent a perceived or actual conflict of interest if you are both a case manager and provider?*

To avoid perceived or actual conflict of interest, HFC conducts business in the open. Case Management organizations are not excluded from providing any services (foster home, in-home supports, supervised visitation, residential care etc.). HFC secures the best possible provider for the services identified. Utilization management is the responsibility of HFC as the lead agency. Case managers do not have the authority to purchase services. Service authorizations are approved through the utilization management unit of HFC, thus avoiding possible conflict of interest.

*What was the impetus for the public agency to contract for case management services and what have the results been?*

After a series of highly publicized cases in which children in the child welfare system were abused, neglected, or even died, numerous approaches were taken to address issues related to lack of funding, low morale, and poor collaboration among agencies. In 1996, Florida legislatively mandated transition to CBC.

*Has the initiative undergone any independent evaluation?*

Yes. In order to determine the cost-effectiveness and quality of services, the Florida Department has contracted with the Louis de la Parte Florida Mental Health Institute (FMHI) to evaluate the CBC agencies. Copies of these reports are available at: http://www.dcf.state.fl.us/publications/pubs.shtml#cbc

*What are the top three issues that public agencies should consider?*

1. The importance of data accuracy, accessibility, and integrity.
2. The complexity of financial reporting (merging governmental accounting into traditional non-profit accounting systems).
3. The importance of strong leadership and the requirement of critical, analytical thinking to ensure viability of the lead agency.

*What are the top three things that private agencies should consider?*

**1. Prevention Capacity.** Prevention is an investment strategy. When properly administered, it will realize cost avoidance. Community engagement through education is an intentional process that increases the effectiveness of primary prevention in the system of care. Agencies need to consider expanding the capacity at the front end of the system of care to manage flow further into the system. Specifically, community awareness and education programs can enhance the collective awareness of citizens regarding their individual responsibility for child safety before harm comes to a child. Establishing and strengthening connections with community service agencies can provide resources for families who simply need help rather than protective services. By diverting those families from moving deeper into the system of care, protective services

resources can be more appropriately allocated toward those families who need them. To increase prevention capacity, Heartland capitalized on the existing prevention awareness infrastructure already in place through the Devereux Kids organization. To further connect resources, Heartland founded a Prevention Awareness Workgroup to keep attention on the ever-expanding network or resources and on the fundamental principle of providing help before harm.

**2. Services Capacity**. Utilization Management is a core business strategy in the system of care to manage resources, increase choice and promote cost efficiency. When developing the range of services in a region, it is critical to consider the unique characteristics of the region and its people. Heartland is located in the methamphetamine capital of the United States. As such, it has been essential that Heartland focus on developing partnerships with substance abuse agencies and providers. Similarly, issues of culture, language, and socio-economics will drive the direction of service and resource development.

**3. System Capacity**. A true "system" of care includes the best characteristics of structure, process, subsystems, information, growth and integration. Heartland has maintained a strong commitment to assure that demand for protective services does not outpace the capacity of the system of care. Not only is there a strong emphasis on the front end through prevention programs and diversion processes, there is an equally strong emphasis on permanency and case closure. Heartland has an aggressive permanency staffing program that assesses children at 5, 8, and 11 months for permanency options. When a case can be closed, Heartland's system of care is designed to link those children and families back into the community for wrap-around aftercare services to help minimize recidivism. By maintaining focus on both the front end and the back end of the system of care, Heartland has been successful in managing the demands on the resources of the system.

*If you had it to do over again, what would you do differently?*

1. Retain the management and delivery of foster care recruitment, re-licensing, and retention.
2. Increase the planning timeline before transition of services.
3. Secure the resources and expertise of specialty areas i.e., financial accounting in the public sector as it relates to the non-profit sector.
4. Allow for planning time before transition of any service, i.e. revenue maximization.
5. Wait until the CBC contract is signed before finalizing performance measures in case management contracts.

*Describe your greatest "success" and your greatest difficulty.*

Greatest Success: Collaboration…collaboration… collaboration.

Difficulty: Development of a successful foster care program, to include: foster parent satisfaction, retention of quality homes, and adequate capacity to offer choice in every placement made.

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## 5. Kansas: Privatization of Family Preservation, Foster Care and Adoption

### Background

In Kansas, the privatization of child welfare services was initiated by the Governor of the state in response to a range of systemic problems that had been identified by the Kansas Department of Social and Rehabilitative Services (SRS). Between July 1996 and February 1997, Kansas utilized a competitive bidding process to select not-for-profit contractors to serve as the lead agencies for the provision of family preservation services, adoption services, and foster care and group home care services. Five contracts for the delivery of family preservation and three contracts for the provision of foster care services were awarded in pre-defined geographical areas of the state; one contract was awarded for the delivery of adoption services throughout the entire state. Each contract contained a case rate and a payment structure based on the achievement of certain milestones. In each contract, there were defined performance goals and requirements that contractors accept all referrals that SRS made to them.

As a result of the contracting out process, not-for-profit agencies undertook responsibility for service delivery (and the necessary day-to-day decision-making). SRS remained the funding source and continued to set and manage policies on the type and quality of services to be provided. In most cases, SRS retained legal custody of the children and continued its role of advising the court of disposition recommendations for children in foster care, including recommendations regarding children's return to the custody of their parents or their being freed for adoption. SRS also retained responsibility for child protective services, thereby continuing to be the "gatekeeper" controlled the number of children who entered and remained in the system.

The experiences of the contractors and SRS varied in each of the service areas that were privatized - family preservation, foster care and adoption.

As noted in a previous section when the contracts were re-bid in 2000, a number of changes were made in the financing, outcomes and performance measures, and in the lead agencies selected to manage the three types of contracts. The re-bid process changed family preservation providers in three of the state's five service regions, foster care providers changed in two regions, and the prime statewide adoption provider changed. The 2000 contracts also included standards for maximum caseloads for all three program areas. Prior to July 1, 2000, maximum caseloads only applied to family preservation (maximum of 10 families). Similar requirements are now specified for foster care/reintegration (maximum of 25 families) and adoption (maximum of 25 children). The independent evaluation looked at findings in each of the three program areas.

In addition to changing from case rates to a monthly fixed rate for foster care and adoption, the state eliminated the provision in previous contracts that allowed the contractors to carve out some children to be served under fee-for-service arrangements. Foster care contractors were still at risk for managing the cost of care and ensuring the child remains home following permanency (12 months for foster care and 18 months for adoption) without additional state reimbursement. The Family Preservation provider continued to receive a case rate.

The 2000 contracts provided the following rates:

- The per child/per month foster care rates are: Region 1 = $1,958; Region 2 = $2,200; Region 3 = $2,174; Region 4 =$1,997; Region 5 = $2,177. The payments are based on the number of children in out-of-home placement the first of each month.
- The adoption per child per month rate is $1,426. Payments cease when the adoptions are finalized.
- After the 2000 procurement, case rates for family preservation services varied by region and ranged from $3,412 to $4,481. One-third of the case rate is paid at the time of referral, and the lead agency is allowed to retain this sum even if the family does not use the services. The remainder of the case rate is paid in two installments, at 45 and 60 days, and is paid in full if the family signs the case plan, regardless of whether they complete the plan.[iii]

In January 2005, SRS announced it has awarded new contracts for adoption, reintegration/foster care and family preservation effective July 1, 2005. The State awarded the new contracts to:

*Family Preservation*: DCCCA, The FARM, and St. Francis.

*Reintegration/Foster Care*: The Farm, KVC Behavioral Health, St Francis and United Methodist

*Adoption:* (one Statewide contract): KCSL

<u>There are some changes in the 2005 contracts</u>:

- The need to transition children between Family Preservation, Reintegration/Foster Care and Adoption contractors has been eliminated.
- The responsibility for the child/family's case management and services will remain, throughout the life of the case, with the contractor who originally receives the referral.
- The statewide adoption contractor will be responsible for recruiting and training a pool of families willing to adopt, providing matching services to the Family Preservation and Reintegration/Foster Care contractors when needed, and providing post adoption support to the family.

In announcing the awards, SRS pointed to successes of the privatization effort:

- Before privatization, family preservation services were available on a limited basis in only 45 counties. Today, family preservation services and community early intervention and family support services are available to at-risk families statewide.
- Prior to privatization, SRS could not ensure an adequate number of stable, family settings for children placed out of home. Today, it is likely that children will be placed in family foster homes, experience stability while in care and stay connected to their family and community.
- Approximately 300 adoptions were finalized each year prior to contracting for adoption services. Today, the average is closer to 500 adoptions per year.

## Interview with A Kansas Lead Agency

The interview was with Mike Patrick, EVP and CEO for the FARM, a lead agency in Kansas since the inception of privatization in 1997.

*Tell me about the Kansas Privatization and how it has evolved.*

Case Management has been privatized for 10 years. The State is divided into 5 service regions.

Case management is divided into the following process: Re-integration case management includes all foster care (Foster homes, groups homes, residential treatment, day care, transportation) and adoption.

Family preservation and all in-home supervision is a separated contract. The need to transition children between Family Preservation, Reintegration/Foster Care and Adoption contractors has been eliminated.

The responsibility for the child/family's case management and services will remain, throughout the life of the case, with the contractor who originally receives the referral

The FARM has been a case management provider for most of this time and currently has 2 large programs (?): Family Preservation in NE Kansas and Reintegration in the SE region.

[this is already stated above: The statewide adoption contractor will be responsible for recruiting and training a pool of families willing to adopt, providing matching services to the Family Preservation and Reintegration/Foster Care contractors when needed, and providing post adoptive support to the family. ] The Adoption Resource Recruitment contractor (KCSL) will serve children who do not have an identified resource by recruiting, training, preparing adoptive families statewide, and supporting subsequent adoptive placements. The Adoption Resource Recruitment contractor is paid a flat monthly fee and is not responsible for case [something is missing to end this sentence]

*Describe your case management model.*

The FARM's case manager basically does the same activities that the public caseworker did in the past: all supervision of the child and family, case plan development, foster placement and supervision.

*How is the family involved?*

The award of new Family Preservation, Reintegration/Foster Care, and Adoption Resource Recruitment services contracts culminates the implementation of family centered practice initiated in 2004. Beginning July 1, 2005, families and children will have continuity of case-management providers for the life of the case regardless of the services needed. [note: this answer does not really address family involvement]

*What is the case plan review process? What is the role of the court in that process?*

The FARM is in the process of validating a 14 point assessment tool that will be administered during the first 20-day evaluation and intake period. This tool predicts the length of out of home care and expectation as to how long it will take for reunification within a 3 month range. The case plan will be developed accordingly and monitored by the FARM's Utilization managers for compliance. Recommendations will be made for the

case plan according to what is needed to meet the needs of the family. [this answer does not address the role of the court – should the question be deleted?]

*What is the interface with Protective Investigations pre-disposition?*

The PI does the investigation, removes the child, places the child for safety and within 72 hours, makes a determination to transfer the case to the FARM. The PI completes a one page referral form and makes the transfer. The FARM Case Manager must hold the first meeting with the family within 24 hours of transfer, the initial assessment must be completed with in 7 days, and the case plan must be developed and agreed to by the Family Team within 20 days.

*Does the Department also have case managers/service workers?*

The Department still has case workers who currently sign off on the case plan and present the case in court. The state is in the process of a pilot project in which the private case manager signs off on the case plan and takes the case to court. The plan is to use this system statewide over the next year. The public case managers are being absorbed into either the private agency or into another department within SRS.

*Are you responsible for court-related processes? What role, if any, does the Department retain in legal processes?*

At the current time, the FARM case workers provide input to the public case manager. That will change over the next year. [not clear how this answer addresses the questions]

*Was there a phase-in process for referrals?*

With this re-bid, the Farm already had the foster care cases. As a result, no phase-in was necessary. (?)

*At what point in the life of a case do you accept cases? At what point does your responsibility end?*

We accept the case from the PI at the point when he/she decides to transfer the child for out of come care or family preservation. We are funded on a capitated case rate basis and our responsibility ends once we return the child home or have a permanency placement or adoption.

*Did the RFP/contract include performance standards—ie, frequency of contact with child, with family or timeframes for case plan development? If so, please describe the performance standards.*

The RFP contains the standards (Coming under separate mailing – please note that information is needed here)

*Is there a direct link between outcomes and payment? If yes, what was the process used to determine which outcomes and measures would be used?*

Payment is based on a capitated case rate that was negotiated. The link with outcomes is through the payment schedule (see below).

*Is case management just one of the services you provide in your contract with the Dept? What other services do you provide?*

The FARM currently provides case management called Reintegration and has a separate contract for family preservation services. Our case management contract includes adoptions and foster care recruitment, training and retention.

*Can you determine what the costs and reimbursement are for the case management component of your contract?*

Yes, as we use an activity- based accounting process.

*What funding source does the Department use to pay for case management?*

Foster care funds IV-E.

*Is your payment schedule linked to performance?*

Payment to Reintegration/Foster Care contractors for services for children in out-of-home care is based on a tiered, incentive system. The tiered system is designed to achieve a more rapid reintegration or alternative permanency by providing higher rates for the first twelve months of service.

The Farm receives payment on a monthly basis, with an average annual case rate of $3,500 per year. That sum is paid out on a monthly basis as follows: 100% per month is paid for the first 6 months, 66% for months 7-12, and 33% for anything over 12 months.

*Do your case managers authorize services for payment or just refer for services? If someone else authorizes service payment, please describe that process.*

Case Managers make recommendations for service and the Utilization Managers make referrals and authorize payment.

*How do the case managers know what services are available?*

They know what services are available from the provider network and based on input from the Utilization Managers.

*What was the principal driving force for the privatization of child welfare services in Kansas?*

SRS contracted for community-based child welfare services in 1996 and is recognized as the first state in the nation to privatize child welfare services. The decision to contract for family preservation, reintegration/foster care and adoption services was driven by the belief that community based child welfare services would yield improved outcomes for children and families. Ten years ago, the privatization was a result of a statewide consent decree. Since SRS dismantled their full case management system, the privatization process continues.

*What are the top three issues that public agencies should consider in developing a plan for contracting for case management?*

1. Make sure the public agency understands what impacts the case management system changes will have on the federal requirements for documentation and regulation. If possible, get the appropriate IV-E and Medicaid waivers. At the current time, Kansas is unable to draw down between $20-45 million due to a mismatch in encounter data.

Kansas did not require the privatized case management agencies to collect all the correct data.

2. The public agency needs to have an idea of the actual expenses to deliver case management (including all direct and indirect costs). Develop a formula to determine the real costs instead of just cost estimates.

3. The public agency needs to have a comprehensive plan to develop "buy-in" from all stakeholders affected by the privatization of case management. Stakeholders include all providers and the legislative and executive branches. The case management organization has to waste a lot of time re-educating the stakeholders…even after 10 years in Kansas.

*What are the top three things that private agencies should consider in developing the capacity to provide case management services?*

1. The private agency needs to have an MIS system that will capture the type of data that is needed to track cases, provide reports to the public agency, develop management reports and capture encounter data and both support the case management system and a utilization management system.

2. Develop a utilization management system which will provide for authorizations of all out of home placement and services. The system should include both preauthorization and concurrent authorizations. At the Farm, the case managers only make case plan recommendations for services; the UM/Care Managers do all the authorizations for payment.

3. The private agency needs to develop a budget and be prepared to pay their mid-level managers higher than average salaries. This is hard work and the staff needs to be compensated accordingly to avoid turnover and make a commitment to making the systems work. The private agency needs to hire skilled social workers for the mid-level management who understand business and the child welfare system and combine both in a philosophical way to produce outcomes.

*If you had it to do over again, what is at the top of the list of things that you would do differently?*

1. Put more resources upfront to handle the transition and implementation process. The first 6 months are chaotic and this is the time to staff up and not cut short on the resources. After this time, turnover can take care of the "extra staff" that you have hired to handle the transition process.

2. Be more careful about developing the proposal and pricing for the procurement process. The Farm submitted 8 contracts and was only awarded 2. The state was concerned that their low bids in some areas would result in poor quality. Achieve a better balance between quality and the proposed budget.

*Describe your greatest "success" and your greatest difficulty.*

Our outcomes have been our greatest success:

Just to identify a few, when we first got our contract, 24% of the total foster care population or 187 kids were in Residential Treatment. We now have 2% or 20 kids in RT. In fact, for the first time since we got the contract, we are seeing few kids placed

in shelter or emergency placement and this past month had 3 days when no kids were in these placements.

Expansion of foster homes from 350, when we first got the contract, to 615 at the current time. We recruit about 200 homes per year due to foster home turnover. Turnover is caused by adoptions, kids aging out, and foster parents retiring or quitting.

Relative placements has increased from 17% to 36% over the course of our contact. We believe that kids return quicker to their homes if they stay, or come back to the community as soon as possible. First by placement in a foster home and then into the birth home.

Our greatest difficulty has been working with the mental health providers. The FARM case management is based on the family treatment and decision making model, but the mental health providers are more individual client based and do not treat the family as a whole and do not want to go into the families home. It is a split system of care with competing treatment models.

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## Adoption- Privatization In Kansas and Massachusetts

### 1. Kansas

Unlike the regionally based contracts for family preservation and foster care, Kansas entered into a statewide adoption contract. Lutheran Social Services (LSS), the sole bidder, was awarded the first contract in October 1996. LSS, as required by its contract, subsequently established subcontracts with 12 adoption service providers across the state. An adoption case rate was established that encompassed all placement services, mental health services, and other services such as day care. LSS and its subcontractors assumed responsibility for recruitment and training of adoptive families, matching children and families, and providing post-adoption supportive services for 18 months following placement. The contract estimated that SRS would initially transfer 1,000 children with adoption as their permanency plan to LSS and that an additional 325 to 425 children would be referred to LSS during the first year.

**Kansas Adoption Outcomes and Performance Standards**

| Performance Measure | Performance Standard |
|---|---|
| Children permanently placed within 180 days (reunification, placement with relative, adoption) | 55% – Year I<br>70% - Year II to 2000 |
| Children permanently placed within 365 days (reunification, placement with relative, adoption) | 70%<br>(new standard added in Year II) |
| Placements finalized within 12 months | 90% |
| Adoptive placements intact for 18 months following finalization | 90% |
| Client satisfaction | 90% |
| Children placed with siblings | 65% |
| Children with fewer than three moves since referral | 90% |
| Children not experiencing abuse or neglect prior to finalization | 95%<br>(new standard added in Year II) |

(State of Kansas, Division of Children and Policy, June 2000)

As with foster care contractors, LSS faced significant problems with the contracted adoption case rate, including a degree of instability in the program. The contracted case rate was set initially at $13,556 for each child for whom adoption planning and services were needed (although SRS had estimated a slightly higher average case rate of $13,756 per child)[iv]. Ten percent of the children were placed outside the case rate because of their medically fragile status or extraordinary medical needs. Under the terms of the first year contract, LSS was paid one-half the case rate when the child was referred to the agency; 25% when the agency placed the child with an adoptive family; and 25% when the adoption was legally finalized.[v] It soon became clear, however, that

the case rate was inadequate, particularly for children with significant special needs. Subsequently, the state revised the case rate upward (to $16,168 for each child in the agency's care), but financial problems continued to plague LSS. In the summer of 2000, LSS declared itself on the verge of bankruptcy as it faced $9.2 million in debt and only $7.3 million in revenue[vi]. Only after an additional infusion of state funds in September 2000 was LSS able to repay its creditors (74 cents on the dollar) and rescind its plans to file for bankruptcy.[vii]

In 2000, the adoption contract was re-bid and was awarded to Kansas Children's Service League (KCSL). Under the earlier contract with LSS, this contract required KCSL to provide independent living and post-adoption services. As occurred with the foster care contracts, SRS changed the adoption reimbursement methodology to a monthly payment for each child in KCSL's care ($1,426 monthly for each child). KCSL, as lead agency, remains financially responsible for children who return to adoption services within 18 months following their adoption. Maximum caseloads have been established at 25 children, a caseload level far larger than recommended by the Child Welfare League of America (2000) when children are older or have special needs (the recommendation is 10-12 children).

Upon assuming the contract, however, KCSL faced a host of challenges in meeting its obligations under the contract. Social workers left their positions more quickly than they could be replaced; the number of children referred for adoption services continued to increase; and the number of agencies willing to subcontract with KCSL to provide adoption services dwindled. The James Bell Associates report (2000) highlighted the growing pressures within the privatized adoption program as increases in the number of children with special needs were freed for adoption (and, therefore, who were more challenging to place with adoptive families). The Legislative Division of Post Audit report (Legislature of Kansas 2001) also verified that although the number of finalized adoptions had increased since privatization, the number of children freed for adoption had outpaced the number of children whose adoptions had been finalized.

In the most recent rebid in 2005, KCSL was again awarded the Statewide contract but with some changes in both reimbursement and scope of responsibilities. Most notably, when a child is referred for adoption support (when there is no identified adoption resource), the case manager assigned to the case at the time of original referral stays the same. KCSL merely provides the required assistance identifying and preparing an adoption resource family and supporting the assigned case manager in working with the child and family to prepare for the adoption. (Information on the rates not available at the time of the report but it appears that the contractor will be paid for accomplishing certain tasks and not a monthly rate).

### 2. Massachusetts-Case Management Contracts for Adoption Cases

Massachusetts procured its most recent adoption case management contracts in July 2005. The Interview was with Joe Leavey, Executive Director of Communities for People.

#### Interview with An Adoption Agency

Communities for People, Inc (CFP) has been providing adoption case management services for the Department since 2000 and was awarded a new 5-year contract as a result of the new procurement in 2005. The contract grants full case management responsibility for adoption cases referred to the provider.

*What is the scope of the adoption contract?*

The Department reimburses providers for six categories of adoption case management services:

1) Consultation provided to area offices for:
- Adoption assessment of a child
- Adoption assessment/homestudy of relatives who wish to adopt
- Assessment/homestudy of foster parents who wish to adopt
- Provision of MAPP

2) Adoption Placement case management services for a child referred by the Department, including assessing the child, preparation for adoption, identification/matching with a pre-adopt family, disclosure to pre-adopt family, preparation of both child and family, post-placement support services, legalization in court, and limited post-legalization support services.

3) Adoption Family Development Services, which includes recruitment and pre-qualification of adults interested in adoption.

4) Time limited recruitment activities for an identified child previously assessed as appropriate/ready fo adoptive placement (particularly focused on older youth who may have a goal of either adoption or guardianship at the time of referral).

5) Intervention Case Services which include the provision of consultation on adoption cases requiring a high level of clinical intervention and at times court involvement.

6) Interstate case services provided for children placed in Massachusetts from other states who have adoption as the goal.

Bidders were allowed to specify some or all of the six case management areas and to indicate the number of referrals of each type that they would receive. Agencies were allowed to limit the geographic area (MA has six service areas) or propose to accept referrals from all Service Area offices.

*Were the outcomes specified?*

The overarching goal is to provide casework to promote the realization of adoption for Special Needs Children. The indicators include:

1. An increase in the families recruited, trained, and approved for special needs children.
2. The number of adoptive placements achieved each year.
3. The number of legalized adoptions achieved each year.

Performance outcome measures focus on the operation of the adoption process and include:

- The length of time required to complete the adoption process
- Pre-adoptive placement disruptions
- Sibling group placements

*What are your case management responsibilities?*

All new referrals are received by the provider's Director of Adoption, who reviews the information included in the referral packet, contacts the referring Area Office to discuss the case in further detail, and reviews the case on FamilyNet (SACWIS). Once the referral is accepted, the Director notifies the Area Central Office, assigns the case to a social worker, and participates in a case transfer meeting with the referring Area Office. From that point forward, the provider ensures that all requested adoption services are provided in an appropriate and timely manner. When clinically appropriate, the provider applies for an adoption subsidy for the child and completes all paperwork necessary to petition the court for the child's adoption. The agency provides post-legalization support to the new adoptive family for a period of three months, then closes the case and returns the case record to the referring Area Office.

Legal services are provided by the Department's legal staff but the contractor prepares all the papers and accompanies legal staff to court hearings.

*How is the Reimbursement Structured?*

With the adoption contract the private contractor does the casework and payment is incremental and attached to completion of various tasks for the six different types of referrals. If at any time the case does not move forward, the provider does not receive additional funds but still provides the case management services. If the case progresses and all payments are made, the rate totals approximately $17,000 per case.

| **Service** | **Product** | **Rate** |
|---|---|---|
| 1. Adoption Consultation | Written Assessment entered into FamilyNet (SACWIS) | $1590 per child |
| | Written assessment of foster/relative family entered into FamilyNet (child in the home) | $1590 per family |
| | Homestudy of relative (child not in the home) | $2000 per family |
| | MAPP certification and written homestudy | $2000 per family |
| | Appearance fee 9copy of dictation) | $240 per activity |
| | MAPP training only | $425 per family |
| Adoption Placement | Family Net SW assigned | $425 per case |
| | Adoption assessment of the child entered into FamilyNet | $1590 |
| | Placement of a child | $3300, $5310, $8025 |
| | Family Development (service referral) | $2650, $4250, $6375 |
| | Re-evaluations | $650, $160, $1590 |
| | Legalization | $3300, $5310, $8025 |
| | Adjustment for cases held 3 years but less than 5 years | $500 per child |

| | | |
|---|---|---|
| | Sibling bonus/legalization | 2= $940, 3= $2000, 4= $3700, 5+=$1180 X# of sibs |
| | Family bonus at time of finalization | $415 per child (minimum of 2) |
| | Closure | $1060 |
| | Delayed adoption (copy of dictation) | $360 |
| | Transfer of case (no activity for 6 months) | $940 |
| 3. Family Development | Presentation of Family Net Service referral | $4000 |
| | Re-utilization of a closed home-updated study | $1415 |
| 4. Recruitment | Child-specific recruitment | $1415 for 6 months |
| | Child Specific recruitment renewal | $1415 for an additional 6 mos |
| 5. Intervention | Separate negotiated rate for services | |
| 6. Interstate | Homestudy | $1590 |
| | SW assigned | $415 |
| | Case supervision | $3300 |

## ENDNOTES

[i] DSS is has decided to use the *Child & Adolescent Needs and Strengths (CANS)* tool. The Child Welfare Institute will provide training on the final selected tool to Lead Agency and Regional Resource Center team members.

[ii] See: http://www5.my.orida.com/cf_web/my.orida2/healthhuman/publications/pubs.html#cbc

[iii] James Bell Associates 2001.

[iv] Craig, 1998 as cited in Freundlich

[v] Belsie, 2000 as cited in Freundlich

[vi] Ranney, 2000a; Miles, 2000 as cited in Freundliich

[vii] Ranney 2000a As cited in Freundlich